Dr. Kevin Olson, D.M.D
4530 S. Carson St. #5
Carson City, NV 89701
Phone: 775-461-3800

Patient Name: _____ Birth Date_____

Patient Name: _____ Birth Date_____

Patient Name: _____ Birth Date_____

For the safety and privacy of our patients, we require written consent to provide treatment for a child accompanied by anyone other than their natural parent or legal guardian. If you anticipate that anyone, including a stepparent, grandparent, babysitter, etc., may bring your child for a dental visit, please complete this form. If you have questions or concerns, please call our office.

I_____, Mother/Father/Legal Guardian of the patient named above, authorize:

Full Name _____ _____ Relationship to Patient _____

Full Name _____ _____ Relationship to Patient _____

to seek and authorize treatment for dental care including routine, surgical, restorative and emergency care provided by Carson City Pediatric Dentistry. I also understand and agree that this consent shall remain in effect until revoked by me in writing.

Phone number where I can be contacted: _____.

Signature_____ Date _____

Circle One: Parent Guardian