NAAS FAMILY DENTISTRY

INFORMED CONSENT

I am the parent or guardian of _____

Who is a minor child, and I do hereby authorize and consent to any x-ray, examination, anesthetic, sedative, or dental treatment rendered under general, direct, or indirect supervision of Dr. J. Matthew Naas and his associates, staff members, or agents, as he may deem necessary. This authorization will remain in effect until cancelled in writing by me.

Parent Signature_____Date_____

Witness_____