AUTHORIZATION FOR DENTAL TREATMENT

The undersigned, the parent and/or legal guardian of _____, a minor, hereby authorizes R.E. Day, DDS; Rachel Turak, DDS; Morgan Nowery, DDS, MSD and staff to do all dental treatment, which may be required for _____, on any given date in the office of Pediatric & Teenage Dentistry, 3000 Hampton Center, Suite B, Morgantown, WV 26505. I, also, give authorization for _____to sign for all necessary treatment which could also include, but is not limited to, x-rays, sealants, restorative treatment, local anesthetic, nitrous oxide, sedation medications, and/or the use of restraints.

_____ _____

Parent/Legal Guardian Date

STATE OF_____

COUNTY OF_____TO WIT:

The undersigned, a Notary Public in and for the County and State aforesaid, does hereby CERTIFY that _____, whose name is signed to the writing above, has this day sworn to and acknowledged the same before me in said County upon authority duly granted.

Given under my hand this _____ day of _____, 20__

_____

Notary Public in and for the State of _____

(SEAL)