Minor Child Treatment Release

I give my permission to Dr. William R. Lindow, DMD and/or his designated assistant to perform any and all dental techniques and procedures, including but not limited to the administration of anesthetics, on my child _____,

whether or not I am present at the actual appointment when the treatment is rendered. I further expressly agree to be financially responsible for all treatment rendered to the above named child.

Signature_____ Date_____

Relationship to child _____