PURVI DESAI, D.D.S., P.C.

995 Route 518
Skillman, NJ 08558
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TREATMENT WITHOUT PARENT/GUARDIAN CONSENT FORM

I, _____, give Dr Purvi Desai/ Insmile dentistry Staff permission to

treat my child, _____, while I am not present, including

Exam/x-rays/cleaning/fluoride/ortho visit/ extraction/cavity fillings/pulpotomy/Space maintainer/_____

The individual bringing my child to the appointment is named, _____ and is at least eighteen years of age and is the patient's _____. I also give this Individual permission to make decisions regarding my child's dental treatment, medical treatment (if necessary should an emergency arise) and behavior management.

I understand payment is expected at the time of treatment.

Parental contact information for questions regarding treatment of the child:

Parent's Name:
_____ Contact Info: (Cell) _____ (Home) _____ (Work) _____
Mailing Address:
_____ City
_____ State _____ Zip Code _____

Signed: _____

Date: _____

Relationship to Patient: _____