



Parental Consent

I, _____, being the parent, guardian or other person entitled to legal custody of _____, a minor child, do hereby authorize and consent to any x-ray, examination or dental treatment to be rendered to said minor child under the general or direct supervision of Dr. James Kozik, DDS as deemed necessary.

I understand that I am financially responsible for all charges incurred regardless of whether or not my insurance pays.

This authorization will remain in effect until termination by the parent, guardian or other person entitled to legal custody of this minor child. Or until they are of legal age.

By signing this form, you also acknowledge that you have had the opportunity to review or received a copy of our Notice of Privacy Practices.

Print: _____

Signature: _____

Date: _____