101 Stevens Memorial Place
Goldsboro, NC 27534
Phone (919)736-4830 Fax (919) 736-7038

I, _____, (Parent Name) give permission to LaFevers Dental Team staff to perform all dental treatment on my child _____(Patient Name) including, but not limited to: fluoride treatments, diagnostic radiographs, examination, composite fillings, sealants and extractions. If additional treatment is needed, LaFevers Dental Team has by permission to perform treatment for all future appointments regardless of my presence in the office. I have informed the staff of all medical changes for my child, and I am also aware that payment is due at the time of service, even if I am not at the scheduled appointment.

_____

Parent/Guardian Signature Date

_____

Authorized LDT Member Signature