

PARENTAL CONSENT

PEORIA: 309.693.0043
7620 N. UNIVERSITY
PEORIA, IL 61614

CHILLICOTHE: 309.274.6237
607 S. 4TH STREET, SUITE B
CHILLICOTHE, IL 61523

Marcin
DENTAL CENTERS

*(Please complete and return with your youth
when not accompanied with and adult)*

Today's Date _____

To Whom It May Concern:

My minor daughter/son _____, has my permission to be treated in the office today.

I give permission for fluoride Yes No

I give permission for x-rays Yes No

Thank you,

Parent Name: _____

Phone to reach parent at appt. time _____

Parent Signature _____