



**CORONADO PEDIATRIC DENTISTRY**  
 Howard R. Dixon, DDS, MS & Associates  
 Diplomate, American Board of Pediatric Dentistry

# CONSENT TO TREAT MINOR

Date: \_\_\_\_\_

As parent(s)/guardian(s) of \_\_\_\_\_ I/We authorize Dr's Howard Dixon and associates to examine and treat my child as necessary. I understand that by signing this form I am accepting all responsibility for full payment of services rendered regardless of insurance coverage. I further understand that all payments are due and payable on the day services are rendered.

Patient Home Address \_\_\_\_\_

City/State \_\_\_\_\_ Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**Dr. Mr. Mrs. Ms.**  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address (if different than above) \_\_\_\_\_

Phone (if different than above) ( ) \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

E-mail Address \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Dr. Mr. Mrs. Ms.**  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address (if different than above) \_\_\_\_\_

Phone (if different than above) ( ) \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

E-mail Address \_\_\_\_\_

**Signature:** \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Friend or Relative not living at same address to contact in the event of an emergency:

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_