Walla Walla Pediatric Dentistry
Stacey Kutsch dds, ms, pllc

614 E. Alder Street, Suite 6
Walla Walla, WA 99362
Phone: 509-522-0555
Fax: 509-876-8200
Email: frontdesk@wallakids.com

CONSENT FOR DENTAL CARE
AUTHORIZATION FOR NON-PARENT/GUARDIAN

Child(ren) name(s):

_____

_____

_____

I give permission for_____;

(relationship to child(ren) _____)

to bring my child(ren) to Walla Walla Pediatric Dentistry for their dental care. Treatment to be performed includes routine pediatric dental services (examinations, cleanings, radiographs, fluoride treatment, and restorative needs as have been already fully explained to me). By signing this form I am providing informed consent for my child(ren) to be treated under the care of Dr. Stacey Kutsch and her team.

This consent shall be effective from date of signature until revoked by parent or legal guardian.

I can be reached at _____.
Phone Number

_____
Signature of Parent/Guardian

_____
Printed Name of Parent/Guardian

_____
Date