



SAN DIEGO PEDIATRIC DENTAL GROUP
 Howard R. Dixon, DDS, MS & Associates
 Diplomate, American Board of Pediatric Dentistry

CONSENT TO TREAT MINOR

Date: _____

As parents of _____, we hereby give Dr. Howard Dixon and associate doctors permission to examine our child. We agree to be financially responsible for all services rendered.

Home Address _____

City _____ Zip _____ Home Phone _____

Father's Name _____

EMPLOYER Name _____

Address _____

Occupation _____

Work Phone _____

Social Security Number _____

Cell Phone _____

Father's Signature _____

Mother's Name _____

EMPLOYER Name _____

Address _____

Occupation _____

Work Phone _____

Social Security Number _____

Cell Phone _____

Mother's Signature _____

Name of Parent with whom child lives: _____

Name of parent financially responsible: _____

Name, address, and phone number of friend or relative not at same residence: _____
