George W. Butz III, D.D.S., P.A.
1517 Third Street SE, Winter Haven, FL 33880

TREATMENT AUTHORIZATION FOR MINORS

Child's Name: ____

I consent to and authorize dental treatment for my child by Dr. Butz and his staff, as prescribed by Dr. Butz. Treatment may include, but will not be limited to cleanings, fluoride treatments, x-rays, injection of anesthetic, fillings, tooth removal, and examinations. I have been informed that should I not understand any explanations given to me or have questions regarding treatment, I am encouraged to seek clarification from Dr. Butz. I am aware that Dr. Butz will make himself available to me to answer any questions I may have before or during the appointment.

Date____________ Signature of Parent of Guardian_______________________