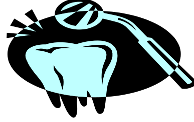
Art of Dentistry



Ayas Family Dentistry, P.C.
3620 S. Cooper St., Suite 140
Arlington, TX 76015
Phone: (817) 468-8839

I am confirming that I am the Parent/Guardian of patient,

____.
Because the patient is under the age of 18, I am granting consent for Dr. Ayas, Assocaites and Staff to do treatment for the above mentioned patient without my present at the office. I understand that because I am not present that I can not hold Dr. Ayas, Associates and Staff liable for anything that might arise do to my absence.

This consent will continue to stay in effect until I provide a written request to terminate.

(__________)______________________________________
Parent/Guardian Emergency Contact Phone Number

____
Print Parent/Guardian Name

____
Signature of Parent/Guardian

____
Date