

Talbot A. Sklar, D.D.S.
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PERMISSION TO TREAT

I, _____, give my permission for Dr. Talbot Sklar and his staff to treat my child, _____, for all dental treatment he/she may need. If additional treatment is found to be necessary, Dr. Sklar has my permission to perform the necessary procedures whether or not I am present in the office.

In the event of an unforeseen emergency, Dr. Sklar has my permission to take any and all necessary steps to ensure the safety and well being of my child.

I acknowledge that I have reviewed this office's Policy on Treatment of Minors. I understand it and I agree to its terms.

Signature of Parent/Legal Guardian: _____

Date: _____