Dental Centers at Family Health Care

1035 East Wilcox
P.O. Box 746
White Cloud, MI 49349
Phone: 231-689-1608
Fax: 231-689-3162

1615 Michigan Avenue
Baldwin, MI 49304
Phone: 231-745-2736
Fax: 231-745-5050

11 North Maple
Suite 200
P.O. Box 7
Grant, MI 49327
Phone: 231-834-9750
Fax: 231-834-1459

520 Cobb Street
Cadillac, MI 49601
Phone: 231-876-6505
Fax: 231-876-6799

Consent Form

Person with legal custody of minor patient ___ Mother ___ Father ___ Both ___ Other

(Legal custody gives a parent the right to seek medical care on behalf of the minor patient. Most parents share joint legal custody).

Patient's Name: ______________________________ DOB: ____________

Please list any other person who may bring the monor patient to Family Health Care Dental:

Step Parent: ____________________ Step Parent: ____________________

Grand Parent: ____________________ Grand Parent: ____________________

Other: ____________________ Relationship to Patient: ______________

Do you prefer to be here for a root canal or extraction of a tooth? Yes No

Does your child have any allergies to any medications? Yes No

If you answered yes, please list: ______________________________

______________________________ ____________
Parent Signature Date

Parent/Guardian Contact Numbers: Home: ______________ Cell: ______________