



Authorization for Treatment

In my absence, I hereby authorize (Please list all people who will be allowed to bring your child to the office for treatment) _____

_____ to accompany (print child's name) _____ for

necessary preventative and/or restorative appointments to Nolensville Pediatric Dentistry, PLLC as deemed by Dr. Ryan Cregger and his associate dentists as well as NPD staff. These procedures could include photographs, x-rays, fluoride treatments, nitrous oxide, possibly even sedation medications. The aforementioned person has my full permission to make decisions concerning treatment of my child, both the day of the appointment and any future appointments. As witnessed by my signature, I will indemnify and hold harmless Dr. Ryan Cregger and his associate dentists and NPD PLLC staff, for all claims arising out of my consent for my child to be treated.

Signature of Legal Guardian

Print name of Parent or Legal Guardian

Date