JAMES A TRUITT, DMD
144 AVENUE B NW WINTER HAVEN FL 33881
863-294-2128

TREATMENT AUTHORIZATION FOR MINORS

Child's Name: _____

I consent to and authorize dental treatment for my child by Dr Truitt and his staff, as prescribed by Dr Truitt. 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. Truitt. I am aware that Dr. Truitt will make himself available to me to answer any questions I may have before or during the appointment.

Date: _____ Signature of Parent or Guardian _____