From the office of Dr. Deborah A. Himelhoch, D.D.S., M.S., M.M.sc.

Patients name (s): _____

I, _____, give _____permission to
(Parent/guardian) (Person accompanying child)

verify health history and make decisions regarding my child's treatment on at Dr. Deborah Himelhoch's office.

X_____

(PARENT or GUARDIAN Signature and Date)