Avni C. Rampersaud, D.D.S., P.A.
205 Sage Road, Suite 202
Chapel Hill, NC 27514
Phone: (919)-929-0489 Fax: (919)-933-3631

Consent for Treatment of Minor Child

I, being the parent or guardian of ______________________ /____________________
(Patient Name) (Date of Birth)
do hereby request and authorize Chapel Hill Pediatric Dentistry and Staff to perform necessary procedures for my child which are deemed advisable by the dentist, whether or not I am present at the actual appointment.

Below is a list of individuals who have my permission to bring my child in for treatment.

□ Patient by him/herself if age 18 years or older. □ I do not give permission

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____ ____________________
Signature of Parent of Guardian / Printed Name Date

____ ____________________
Witness Date