

RUSHMORE D E N T A L

Tim Kelly DDS
1600 Mountain View Rd. Suite 104, Rapid City, SD 57702
605-593-0037

Consent for Treatment

I am the (parent or guardian) of _____, who is a minor child, and I authorize the necessary examination and treatment by or under the supervision of Dr. Kelly. This includes, but is not limited to, exposure of radiographs as necessary, application of local anesthetic, and use of medication and materials for treatment.

Parent/Guardian

Date