



**Heather T. Hudkins, DDS, PC**  
General Dentist

**William V. Brell, Jr., DDS, MSD**  
Pediatric Dentist

### PERMISSION FOR TREATMENT

Patient Name \_\_\_\_\_

I (being the parent or legal guardian of the above minor patient) hereby do authorize and request the performance of dental services for this patient and the use of whatever procedures Dr. Brell or Dr. Hudkins may deem necessary during treatment.

I understand that Dr. Brell or Dr. Hudkins and such assistants as he may designate to treat the above mentioned patient will use restorative, oral surgery and patient management techniques that are reasonable, necessary and advisable.

I also authorize the administration of anesthetics or analgesics which may be deemed advisable by Dr. Brell or Dr. Hudkins.

I understand that the treatment plan to be presented, along with the fees outlined, could change depending upon the time elapsed since the initial examination and the extent of dental pathology. I understand that any treatment proposal given to me is simply an estimate based on the information I provide. Furthermore, by signing this, I agree to be responsible for full payment of all charges for dental services performed on the above-name patient.

Date \_\_\_\_\_

Signed \_\_\_\_\_

Relationship \_\_\_\_\_

Witness \_\_\_\_\_