William L. Eick, D.D.S.
21851 Center Ridge Road, Suite 415
Rocky River, Ohio 44116
440-333-1915
440-333-1614 fax
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PERMISSION TO TREAT

Dr. Eick,

I hereby authorize you and your dental staff to treat my son/daughter, _____.

You have my permission to complete all necessary dental

services such as exams, cleanings, x-rays, fluoride and sealants.

If you have questions, I can be reached at _____.

_____

Parent or Guardian Date