

William L. Eick, D.D.S.  
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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