



KENNETH  
SCHWARTZ  
DDS  
*family dentistry*

833 UNION STREET  
SCHENECTADY  
NEW YORK 12308  
518.374.1935

## Minor Treatment Consent Form

I, \_\_\_\_\_ give my permission to the staff of Kenneth D.  
legal guardian/parent

Schwartz DDS to perform the following (checked) dental services on

\_\_\_\_\_, a minor I am legally responsible for.

\_\_\_\_\_  
legal guardian/ parent

\_\_\_\_\_  
date

fillings \_\_\_\_\_

cleaning \_\_\_\_\_

bitewings \_\_\_\_\_

full mouth x-ray \_\_\_\_\_

fluoride treatment \_\_\_\_\_