YORK COUNTY PEDIATRIC DENTISTRY
DR. GARY CREISHER
5 WEBHANNET PLACE – SUITE 1 KENNEBUNK, ME 04043
207/985-2800 (FAX 207/985-7185)

RELEASE FORM

As the parent / legal guardian of _____, I request that in my absence the above-named child be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and xray treatment of the above minor. I have not been given a guarantee as to the results of examination of treatment. I authorize the hospital or medical/dental facility to dispose of any specimen or tissue taken from the above named minor.

Child's Date of Birth: _____/_____/_____ Date of Last Tetanus Booster _____/_____/_____

Known allergies of this child, including allergies to medicine:
_____
_____
_____
Any other medical problems which should be noted:
_____
_____
_____

Family Physician: _____Phone # :_____

I, _____give permission for

_____ (relationship to patient) _____

To bring my child to the office of York County Pediatric Dentistry, Dr. Gary Creisher . I am

allowing the above named person to make any needed decisions that may arise during the appointment.

Date: _____

Signature of Parent/ Legal Guardian: _____