KIZIOR & YOUNG

ORTHODONTICS

Specialists in Orthodontics and Dentofacial Orthopedics for Children & Adults

PERMISSION FOR TREATMENT

AN ADULT MUST ACCOMPANY MINOR CHILDREN. PLEASE COMPLETE PERMISSION SLIP IF YOU, AS THE GUARDIAN, ARE UNABLE TO BE PRESENT AT THE SCHEDULED ORTHODONTIC APPOINTMENT.

PATIENT: _____

In my absence, I _____as the responsible party for the above Named patient, give permission to **Dr. John W. Kizior** and **Dr. Derrick R. Young** to provide an Orthodontic examination to _____ my son/daughter, during his/her scheduled appointment date of _____.

I also give permission to **Dr. John W. Kizior** and **Dr. Derrick R. Young** and/or his staff members permission to complete the following diagnostic procedures at the scheduled appointment if treatment indicated and recommended by **Dr. John W. Kizior** or **Dr. Derrick R. Young**.

PANORAMIC X-RAY
CEPHALOMETRIC X-RAY
DIAGNOSTIC PHOTOS
DIAGNOSTIC CASTS

I understand the above diagnostic procedures are necessary for Dr. John W. Kizior and Dr. Derrick R. Young to develop a diagnosis and orthodontic treatment plan. Following the initial examination a phone call will be placed from the office of Kizior and Young Orthodontics to the responsible party of the above named patient informing of the next appointment steps prior to beginning orthodontic treatment.

_____ _____

RESPONSIBLE PARTY SIGNATURE **DATE**