Guardian Form

Date: _____

Patient: _____ DOB: _____

Appointment(s) length of time: _____

Dakota Dental needs the following information **before** scheduling appointment(s):

Is the patient their own guardian (circle one): YES NO

Is the attached treatment plan signed and dated (circle one): YES NO

If the patient is not their own guardian, please complete the following guardian information for the listed patient:

Phone Number: _____

Address: _____

Guardian print name: _____

Guardian signature: _____ Date: _____

(1) The Guardian Form and signed Treatment Plan must be completed and returned to Dakota Dental before any treatment is scheduled.
(2) Dakota Dental will call to schedule the appointment(s) when both forms are received.
(3) Please fax (605) 332-9560 or email (frontdesk@dakotadentalsd.com) the attached treatment and Guardian Form.