

# PEDIATRIC DENTISTRY

Dr. Kevin L Rencher D.D.S.  
Infants | Children | Teenagers  
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Name of Child(children) \_\_\_\_\_

I \_\_\_\_\_ give Dr. Kevin Rencher's office permission to speak to the following people regarding my child(children)'s treatment, appointment times, and financial account information.

Name

Relationship to Patient

_____	_____
_____	_____
_____	_____
_____	_____

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date