The Dentists' Office

GENTLE CARE THROUGH TECHNOLOGY

AUTHORIZATION FOR MINOR CHILD ACCOMPANY

Child's Name: _____ Date of Birth: _____

I, _____ give _____
(Parent or Legal Guardian's Name) (Authorized Person's Full Name)

my permission to accompany my child to The Dentists' Office for his/her appointment and to make necessary decisions regarding dental treatment for my child including, but not limited to:

- Sign informed consents for preventative appointments
- Discuss post-operative instructions
- Discuss finances, treatment charges, insurance estimations, account balances and next visit charges
- Discuss dental findings, future dental treatment needs and any pertinent personal health information

As the parent or legal guardian, I understand that I must sign any treatment plans and or informed consents before any restorative procedures or invasive dental treatment can be performed for my child. I further understand that it is my responsibility to provide payment or a source of payment on the day that services are rendered, even when this authorized person brings my child.

Signature of Parent or Legal Guardian: _____ Date: _____

Witness: _____ Date: _____

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