Authorization for a Minor Child

Patient First Name Patient Last Name Patient DOB

I give my permission to the below authorized person(s) to accompany my child to the dental office. The Dental Specialists-Pediatric Dentistry for all dental appointments. I also give permission to the below authorized person(s) to make any necessary decisions regarding dental treatment.

- Consent to sign all forms required to give The Dental Specialists-Pediatric Dentistry permission to treat any dental needs of my child.
- Consent to sign any treatment plans once presented (this does not obligate you to do treatment but is used to inform you of your child's dental needs).
- Discussion of treatment finances including treatment charges, account balances and next visit charges.
- Discussion of future dental needs (i.e. treatment plans).
- Consent to schedule future dental appointments for my child.

Authorized person	Phone Number	Relationship
Authorized person	Phone Number	Relationship
Authorized person	Phone Number	Relationship
Authorized person	Phone Number	Relationship

Authorized Signature: _____ Date: _____