DEDICATED DENTAL SERVICE

AUTHORIZATION FOR TREATMENT OF MINOR PATIENTS

Please read throughly before signing.

Patient's Full Legal Name:

First _____ Last_____ Date Of Birth ___ /___ /_____

First _____ Last_____ Date Of Birth ___ /___ /_____

First _____ Last_____ Date Of Birth ___ /___ /_____

I authorize the following adult individuals to accompany the above-mentioned patient(s) to the office of Dedicated Dental Service for the purposes of obtaining dental care. This dental care may include any treatment or diagnostic procedure the Doctors may see necessary.

Please also list parents:

Name _____ Relationship to patient_____Phone_____

Name _____ Relationship to patient_____Phone_____

Name _____ Relationship to patient_____Phone_____

Name _____ Relationship to patient_____Phone_____

Parent/Legal Guardian Signature _____ Date ___ /___ /_____

Printed Name _____

**** PLEASE be aware, a non-custodial parent, whose insurance covers any patient(s) will have full access to their Dental records even if this parent is not listed above.