General Dentistry Authorization for Non-Guardians

I hereby authorize the following responsible adults to accompany _____ to
Patient Name

appointments for routine dental care. This includes, but is not limited to, a periodic exam, prophylaxis, x-rays as designated by the dentist, and fluoride treatment. I am aware that any treatment that requires my presence will not be performed until I can be physically available to consent, such as fillings, extractions, or any specific concerns that must be addressed with a legal guardian as determined by the general dentist. I agree to make myself available to be reached at the phone number below during any appointment where I will not be physically present. I understand that it is my obligation, not that of *smile*builderz, to ensure that any person accompanying the patient identified above to an appointment is a responsible adult who will remain inside the office while the child is being seen, and safely transport the patient to and from the appointment.

NAME	RELATIONSHIP	DATE
NAME	RELATIONSHIP	DATE
NAME	RELATIONSHIP	DATE
NAME	RELATIONSHIP	DATE

_____ _____
Printed Minor Patient's Full Name Minor's Date of Birth

_____ _____
Signature of Minor Patient's Parent/Legal Guardian Phone Number

_____ _____
Printed Name of Minor Patient's Parent/Legal Guardian Date

_____ _____
Witness Signature Date

Updated 4/11/2017