Authorization For Minor Child

Child's Full Name: _______________________________ DOB: ___________________

I, __________________________________, give _________________________________

(Parent or Legal Guardian) (Authorized Person Full Name)

Permission to accompany my child to the office of **All About Kids Pediatric Dentistry** for dental appointments. I also give __________________________________ permission to

(Authorized Person Full Name)

Make any necessary decisions regarding dental treatment for my child, including but not limited to:

- the consent for this authorized person to sign any and all forms required to give permission to **All About Kids Pediatric Dentistry** to treat the dental needs of my child,
- the consent to the dental practice to discuss finances (treatment charges, account balances, next visit charges) with this authorized person,
- The consent to the dental practice to discuss my child's future dental treatment needs, (i.e. treatment plans),
- The consent for this authorized person to sign my child's treatment plan once it has been presented by the dental staff. I understand this does not obligate me to the treatment, only that the office has informed me or my representative of the dental needs of my child,
- The consent for this authorized person to schedule future dental visits for my child.

I understand this consent will be valid for one year or until I rescind this agreement in writing.

____ ___________________

Signature of Parent or Legal Guardian Date

____ ___________________

All About Kids Pediatric Dentistry Date