



NON PARENT AUTHORIZATION

I authorize _____
(name of the person bringing the patient/minor)

to escort my child _____ to his/hers dental appointments during my absence.

I approve the following treatments to be done to my child:

- Exam
- X-rays (If necessary)
- Cleaning
- Fluoride
- Fillings
- Extractions
- Emergency treatments (If necessary)

I request to be contacted to the phone number listed below if there is any change in treatment plan, if any other recommendations are needed during the treatment.

Phone number: _____ Date: _____

Parent/Guardian name: _____

Signature: _____