# Dental Treatment Authorization Form

Patient Name: ____________________________________________

DOB: ____________________________________________

## Designated Adult Information

Name: ______________________ DL/Valid ID#: ______________________

Address: ____________________________________________

Cellphone: ______________________ Email: ______________________

Relationship with Patient: ____________________________________________

Signature of Designated Adult: ____________________________________________

Emergency Contact (If parents are not available): ______________________

Cellphone: ______________________ Email: ______________________

I authorize ______________________ to make any dental and medical decisions, including accompanying my child to clinic visits and consent to any changes in the treatment plan as they may arise at the time of the treatment, where the minor is not accompanied by either parents or legal guardians, and may not be feasible or practical to contact them. I agree to pay for my portion of the services provided to my child same day, if any, as the treatment is rendered.

Parent/Guardian's Name: ____________________________________________

Cellphone: ______________________ Email: ______________________

Signature of Parent/Guardian: ____________________________________________