AUTHORIZATION FOR PARENT-DESIGNATED ADULT TO ACCOMPANY MINOR DURING DENTAL APPOINTMENTS

Patient Name: _____

DOB: _____

Address: _____

Designated Adult Information

Name: _____ DL/Valid ID#: _____

Address: _____

Cellphone: _____ Email: _____

Relationship with Patient: _____

Emergency Contact (If parents are not available): _____

Cellphone: _____ Email: _____

I, the undersigned, hereby authorize the designated adult named above to accompany my minor child during dental appointments at Bethel Kids Dental and provide any necessary verbal or written consents regarding dental procedures, treatments, or decisions on my behalf.

- This authorization grants the designated adult the ability to accompany the minor child to dental appointments, discuss treatment plans, and make decisions if required.
- The designated adult authorized to sign consent for any dental procedures or treatment decisions during the appointment without prior consultation with me, the legal guardian.
- This authorization will be valid for dental appointments until revoked in writing.

Parent/Guardian's Name: _____

Parent/Guardian Signature: _____

Cellphone: _____ Email: _____