AUTHORIZATION FOR DENTAL TREATMENT

The following individuals are permitted to authorize any changes in dental treatment during the visits for_____ as recommended by Dr. Dermody:
print child's name

_____ _____
print name relationship

_____ _____
print name relationship

_____ _____
print name relationship

Further, these persons can provide full medical/dental history for this child, and will also have full authority to authorize financial arrangements for any additional treatments rendered.

I understand that as Parent/Guardian for this child, I am fully responsible for payment of any services provided.

_____ _____
Parent/Guardian Signature Date