Authorized Contacts

Patient's Name (s):____Birth Date:____________

Patient's Name (s):____Birth Date:____________

Patient's Name (s):____Birth Date:____________

Patient's Name (s):____Birth Date:____________

I, _______________________ hereby authorize the following named party(s) permission to be able to call and schedule or change appointments, to bring my child(ren) in and act on my behalf for their necessary dental needs and to share account or dental health information. (*I.e other parent, grandparent, etc*)

Name:____ Birth date:_________________

Relation:____________________________ Primary Phone: __________________________

Name:____ Birth date:_________________

Relation:____________________________ Primary Phone: __________________________

Name:____ Birth date:_________________

Relation:____________________________ Primary Phone: __________________________

Name:____ Birth date:_________________

Relation:____________________________ Primary Phone: __________________________

Parent/Guardian Signature:____

Print Name:____ Date:__________________

Adventure Dental
Pediatric Dentistry and Orthodontics