Authorized Contacts

Child's Full Name:____Birth Date:____________

Childs's Full Name:____Birth Date:____________

Child's Full Name:____Birth Date:____________

Child's Full Name:____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: _________________________

Email:____

Name:____ Birth date:_________________

Relation:___________________________ Primary Phone: _________________________

Email:____

Name:____ Birth date:_________________

Relation:___________________________ Primary Phone: _________________________

Email:____

Name:____ Birth date:_________________

Relation:___________________________ Primary Phone: _________________________

Email:____

Parent/Guardian Signature:____

Print Name:____ Date:__________________