

Authorized Contacts



Child's Full Name: _____ Birth Date: _____

Child'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: _____