

PREMIERE DENTISTRY OF TAHLEQUAH

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Mark D. Smith, D.D.S. Matthew B. Hodgson, D.D.S.

AUTHORIZATION FOR TREATMENT OF MINOR

I hereby authorize and give permission to:

Name(s): _____
person(s) bringing patient(s) to appointments

Relation(s) to Patient: _____

to take my children to Premiere Dentistry to seek dental treatment. This authorization will also give permission to person(s) named above to sign the specific treatment consent forms that are required.

This authorization applies to the following patients:

Name: _____ DOB: _____ Use Nitrous? Yes/No (circle)

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Name: _____ DOB: _____ Use Nitrous? Yes/No (circle)

Name: _____ DOB: _____ Use Nitrous? Yes/No (circle)

If needed, where can we contact you from 8-5?

Parent/Guardian giving permission:

Printed Name

Signature

Date