Permission Form

Date: _____

Patient(s) Name(s):_____

I, _____, give the individuals listed below permission to bring my child(ren) to their dental visits and authorize Center for Pediatric Dentistry to give them any information regarding dental care for my child(ren). The have full authority to make any dental and financial decisions for my child(ren), including but not limited to: sedation, nitrous oxide, radiographs, and fluoride treatments. I understand that payment for services rendered is due at the time of treatment and agree to make payment arrangements with Center for Pediatric Dentistry if the individual accompanying my children is not prepared to make payment in full. Center for Pediatric Dentistry will make every effort to keep the accompanying adult informed before treatment is changed, however I realize that this may not always be possible and the adult will be informed of any changes at the completion of the appointment. I understand that if I need to make any changes to this agreement I must do so in writing.

Name	Phone Number(s)	Relationship to Patient
1.		
2.		
3.		
4.		
5.		
6.		

Parent/Legal Guardian Signature: _____

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