Authorization for Minor Child

I give permission for the aforementioned person(s) to accompany my child to the office of Booe Pediatric Dentistry for dental appointments. I also give the name person(s) permission to make necessary decisions regarding dental treatment for my child, including but not limited to:

1. The consent to sign any and all forms required to give permission to Booe Pediatric Dentistry to

treat the dental needs of my child.

2. The consent of the dental staff to discuss finances (treatment charges, account balances, next

visit charges).

3. The consent of the dental staff to discuss my child's future dental treatment needs (treatment

plans).

4. The consent to sign my child's treatment plan once it has been presented by the dental staff. I understand this does not obligate me to the treatment, only that the office has informed me or my representative to the dental needs of my child.

5. The consent for this person(s) to schedule future dental visits for my child.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____