First Smiles
PEDIATRIC DENTISTRY

AUTHORIZATION FOR MINOR CHILD ACCOMPANY

Child(ren)'s full name (s):_____

DOB (s):_____

I,_____give First Smiles Pediatric Dentistry

(Parent or Legal Guardian) (Authorized Person's Full Name)

Permission to accompany my child to the office of First Smiles Pediatric Dentistry for dental appointments. I also give permission to First Smiles Pediatric to make necessary decisions regarding dental treatment for my child including, but not limited to:

- The consent for this authorized person to accompany my child for exams, dental cleanings or restorative treatment and to discuss post-operative instructions.
- The consent of First Smiles Pediatric Dentistry to discuss finances (treatment charges, account balances, next visit charges) with this authorized person.
- The consent for this authorized person to discuss my child's dental findings, future dental treatment needs and any pertinent personal health information (PHI).

As the parent or legal guardian, I understand that I must present to the office, in person, to sign any treatment plans or informed consents before any restorative procedures or invasive dental treatment can be performed for my child. I further understand that it is my responsibility to provide payment or a source of payment on the day that services are rendered, even when this authorized person brings the child, or no treatment will be performed for my child.

Signature of Parent (legal Guardian) **Date**

_____ _____

First Smiles Pediatric Dentistry Representative **Date**

_____ _____