Diane L. Lide, DDS, PC

Frisco Pediatric Dentistry

AUTHORIZATION FOR A MINOR CHILD

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

DOB(s):_____

I, _____(Parent or Legal Guardian) give_____(Authorized person's full name) permission to accompany my child to the office of Frisco Pediatric Dentistry for dental appointments. I also give permission to _____ (Authorized person's full name) 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 the staff of Frisco 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 or Legal Guardian) (Date)

_____

(Frisco Pediatric Dentistry Representative) (Date)

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