LONESTAR KID'S DENTISTRY

AUTHORIZATION FOR MINOR CHILD

Child or children's full name(s) with Date of Birth:

_____

I, _____ give _____
(Parent or Legal Guardian) (Authorized Person's full name)

permission to accompany my child to the office of Lonestar Kid's Dentistry for dental appointments.

I also give permission to _____
(Authorized Person's full name)

to make any necessary decisions regarding dental treatment for my child including but not limited to:

- The consent for this authorized person to sign any and all forms required to give permission to Lonestar Kid's Dentistry to treat the dental needs of my child.
- The consent to the dental practice to discuss finances (treatment charges, account balances, next visit charges) with this authorized person.
- The consent to the dental practice to discuss my child's future dental treatment needs (i.e. treatment plans).
- The consent for this authorized person to sign my child's treatment plan once is 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 of the dental needs of my child.
- The consent for this authorized person to schedule future dental visits for my child.

I understand this consent will be valid for one year or until I rescind this agreement in writing.

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Lonestar Kid's Dentistry Representative Date