Authorized Person(s)

In the event that my child needs dental treatment and I am not able to bring them to the visit, I authorize the follow individuals to bring him/her and authorize any treatment needed in my absence. Anyone not listed below will not be able to authorize treatment in our office. I am responsible to contact Mayfield Family Dentistry and make them aware if any of the authorized people change.

_____

_____

_____

_____

_____

_____

Patient Name:_____ Date of Birth:_____

Signature of Parent/Legal Guardian:_____

Date Signed:_____ Witnessed by:_____