ALL KIDS SMILE
PEDIATRIC DENTISTRY

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www.allkidssmile.com

To All About Kids Pediatric Dentistry

I, ____,give

All Kids Smile Pediatric Dentistry permission to treat my child(ren):

- ____
- ____
- ____

while I am not present. The individual bringing my child(ren) to the appointment is named____and is at least (18) years of age, and is the patient's_____________________________(*relationship to child*).
I understand that medical/dental advice will be relayed to them on my behalf. I understand and agree that the signature and dates on this form will not expire without written notice and that a photocopy of this form is considered valid as the original.

Relationship to the child(ren):___________________________Date:_____________

Parent/Legal Guardian Signature: ____

Parental Contact information
Parent's Name:_____________________________________
Contact info: (Cell)______________Home_______________Work_________
Mailing Address:____
City_______________________________State_______________Zip Code_____________
Date:________________