"DR. PADDY" A.Patrick Smithwick III, D.D.S., P.L.L.C.
Board Certified Pediatric Dentist

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Authorization For Minor Child

Child's Full Name: ______________________________ DOB: __________________

I, _____________________________________, give ____________________________ permission to accompany my child to the office of A. Patrick Smithwick III, D.D.S., P.L.L.C. for dental appointments.

I also give permission to ______________________________ to make 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 A. Patrick Smithwick, D.D.S., P.L.L.C. 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 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 it 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