Authorization For Minor Child

A. Patrick Smithwick III, DDS
Board Certified Pediatric Dentist

Roger J. Castro, DDS
Board Certified Pediatric Dentist

KIDS MILE HIGH
PEDIATRIC DENTISTRY
ORTHODONTICS

Child's Full Name: ______________________________ DOB: ____________________

I, ______________________________ , give ______________________________ permission to accompany my child to the office of Kids Mile High Pediatric Dentistry 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 Kids Mile High Pediatric 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 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

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