Authorization For Minor Child

A. Patrick Smithwick III, DDS
Board Certified Pediatric Dentist

Roger J. Castro, DDS
Board Certified Pediatric Dentist

Meredith M. Ghivizzani, DMD
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