Macomb children's dentistry

Authorization For Minor Child

Child's Full Name: _____ DOB: _____

I, _____, give _____
(Parent or Legal Guardian) (Authorized Person Full Name)

permission to accompany my child to the office of **Macomb Children's Dentistry** for dental appointments. I also give permission to _____ to make any necessary decisions regarding dental treatment for my child, including but not limited to:
(Authorized Person Full Name)

- the consent for this authorized person to sign any and all forms required to give permission to **Macomb Children's 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 this 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

_____ _____
Macomb Children's Dentistry Date