Pediatric Dentistry, P.C.
Developing Healthy Smiles
Brent D. Johnson, DDS, MS

Consent for Treatment Authorization

_____ Child's Name and Date of Birth	_____ Child's Name and Date of Birth
_____ Child's Name and Date of Birth	_____ Child's Name and Date of Birth
_____ Child's Name and Date of Birth	_____ Child's Name and Date of Birth

I authorize the following persons to accompany my child/children named above to their appointments and authorize them to act in my place with respect to any and all medical or dental matters if I am not able to accompany my child. *(Note: you are not required to authorize any other individuals if the patient will always be accompanied to his/her appointments by a parent or legal guardian.)*

Name	Phone #	Relationship to Patient
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____
Signature of Parent/Guardian Date