PERMISSION TO ACCOMPANY

I hereby authorize the following person(s) to act in my behalf to obtain treatment for my child in my absence:

Patient's name: _____ DOB: _____

Name of person accompanying patient: _____

Relationship to child: _____

Phone number: _____

Revoke Date: _____

Name of person accompanying patient: _____

Relationship to child: _____

Phone number: _____

Revoke Date: _____

Name of person accompanying patient: _____

Relationship to child: _____

Phone number: _____

Revoke Date: _____

_____	_____	_____
Name of parent/guardian	Signature of parent/guardian	Date

Please email this completed form to info@adavenpediatricdental.com fax to (702) 492-7663 or bring to the appointment. Thank you.