Mission Hill Dental

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AUTHORIZATION FOR DENTAL TREATMENT OF MINORS

Name of Minor(s)	DOB	Allergies/Special Conditions

I/We, being the parent(s) or legal guardian(s) of the above named minors (s), do hereby:

☐ Authorize patient to obtain treatment unaccompanied by an adult

☐ Understand that payment may be due and I will be billed accordingly

☐ Acknowledge there have been no health changes. I understand it is my obligation to notify the dental office of any health changes prior to my child's appointment.

Parent/Guardian Name:_____Date:_____

Signature of Parent/Guardian:_____