SCOTT T. ROWLEY, D.M.D., M.S.D.
DIPLOMATE, AMERICAN BOARD OF PEDIATRIC DENTISTRY

BENJAMIN D. RUDER, D.D.S.
DIPLOMATE, AMERICAN BOARD OF PEDIATRIC DENTISTRY

ROSALEEN J. SHAVRON, D.M.D.
DIPLOMATE, AMERICAN BOARD OF PEDIATRIC DENTISTRY

Authorization for Others to Consent to Dental Care

I hereby give permission for ____,
Relationship:____, to bring my child(ren) Into this office for dental care. This includes, but is not limited to, examinations, dental cleanings, fluoride treatments, x-rays, and restorative care. He or she also has my authorization to make any decision based on Dr. Psaltis, Dr. Rowley, Dr. Ruder or their associate's recommendation(s) regarding treatment in my absence. I agree to assume financial responsibility for his &/or her decisions.

This consent is valid from date signed until revoked by parent or legal guardian.

This consent is valid for the child(ren) listed:

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____

____ Date__________________
Signature

____ Relationship_____________
Please print name

I can be reached at ______________________________if needed.
Phone number

Photo copy is valid as original

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