Authorization for Others to Consent to Dental/Orthodontic Care

I hereby give permission for:

Name________________Name____________________Name______________________

Relationship_____________Relationship________________Relationship____________

To bring my child(ren) into this office for dental care. This includes, but is not limited to, examinations, orthodontic care, dental cleanings, fluoride treatments, x-rays, and restorative care. He or she also has my authorization to make any decision based on Dr. Derek Busciglio and his associate's recommendation(s) regarding treatment in my absence. I agree to assume financial responsibility for his/her decisions. I also give permission for those named above to have any Ortho/ Dental treatment/Medical History reviewed and discussed.

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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Signature______________________________ Date__________

Please print name___________________________ Relationship____________

I can be reached at _____________________ if needed.

(Phone number)