Consent by Proxy for Dental Treatment

Please list any adult(s) (proxy) that may be bringing your child(ren) to their dental visits that will be able to consent for their dental treatment and inform us of their medical history. Be advised that protected patient health information may be shared with the proxy to facilitate informed decision making.

Proxy Name:	**Relationship to the Child:**	**Phone #:**

This consent form applies to the following child(ren):

Child Name:	**Date of Birth:**

If there are any limitations for the types of dental services for which this consent by proxy is given, please list below (if none, state “None”):

If there are any limitations for the time frame for which this consent by proxy is given, please list below (if none, state “None”):

Contact information for Parent(s) and Legal Guardian(s):

Parent Name: _____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____

Parent Name: _____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____

I consent to have the above listed proxies consent to dental treatment for my child(ren).

Signature: _____
Date: _____

Signature: _____
Date: _____