



CONSENT FORM

I, _____, am unable to bring my
(Parent / Guardian Name)

child, _____, _____,
(Child's Name) (Date of Birth)

to Pediatric Dentistry of Lewisburg for his/her appointment. I can be reached at the following phone number(s) for any questions.

Home phone: _____

Work phone: _____

Cell phone: _____

I give consent to the following persons (designees) to accompany my child to their dentist appointment. I agree to inform the designees of their need to show proof of identification to the personnel at Pediatric Dentistry of Lewisburg. I also give consent for the designee to authorize any treatment.

(Authorized Person) (Date)

(Authorized Person) (Date)

(Authorized Person) (Date)

(Authorized Person) (Date)