A SAFARI DENTAL

Children's Dentistry and Orthodontics
4427 Rowan Road
New Port Richey, FL 34653
Phone: (727)834-8585 **Fax: (727)264-0651**

ADD'T PARENT/GUARDIAN ACCOMPANYING A MINOR PATIENT CONSENT FORM

I _____ authorize _____ to bring my child/children for their dental visit.

Child's Name: _____Date of Birth: _____

Child's Name: _____Date of Birth: _____

Child's Name: _____Date of Birth: _____

Child's Name: _____Date of Birth: _____

Child's Name: _____Date of Birth: _____

Child's Name: _____Date of Birth: _____

Child's Name: _____Date of Birth: _____

This authorization will serve as consent for the named party above to make treatment decisions, financial arrangements, and make payments on behalf of the patients listed.

Signature of Legal Parent/Guardian:

Date: