RGV endodontics LLP

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AUTHORIZATION – DENTAL CARE OF A MINOR PARENT NOT PRESENT

Date: _____

Patient: _____

Patient Date of Birth: _____

Person(s) I authorize to accompany my child:

Name _____ Relationship to child: _____

Name _____ Relationship to child: _____

Name _____ Relationship to child: _____

This is an authorization for the office of, Iván E. Rodríguez, D.M.D., Adalí Efraín Vélez, D.M.D., Ernesto G. Treviño, D.D.S., and their assistants as they may designate, to render dental care to my child. I consent to any dental care which encompasses diagnostic or dental treatment which my dentist or their designee may deem necessary for my child's dental health and well-being.

This authorization will remain effective unless terminated by written notice.
Phone number where parent can be contacted during treatment, if needed:

Cell phone number: _____

Work phone number: _____

_____ _____
Signature of Parent or Legal Representative Date

_____
Relationship to Patient

_____ _____
Witness Date