MAGNA DENTAL, PC

1825 S 6TH
SPRINGFIELD, IL 62703
217-525-6980
(REVISED 1-25-2017)

I _____, (_____)
(PARENT/GUARDIAN'S NAME) (RELATIONSHIP TO MINOR)

AUTHORIZE THE FOLLOWING ADULTS TO ACCOMPANY THE MINOR: _____. FOR ALL DENTAL APPOINTMENTS IN MY ABSENCE.

ADULTS:	RELATIONSHIP TO MINOR:
_____	_____
_____	_____
_____	_____

*I GIVE MY CONSENT FOR DENTAL CARE/TREATMENT. I GIVE MY CONSENT FOR THE STAFF OF MAGNA DENTAL TO DISCUSS CARE, TREATMENT, COST, AND/OR MEDICAL INFORMATION WITH THESE ADULTS. I GIVE CONSENT FOR THESE ADULTS TO MAKE TREATMENT DECISIONS ON MY BEHALF. I UNDERSTAND THAT THE MINOR MUST BE ACCOMPANIED BY ME OR ONE OF THE AFOREMENTIONED ADULTS FOR EVERY APPOINTMENT UNTIL THE MINOR TURNS 18 YEARS OLD. I UNDERSTAND THAT IF AN ADULT IS NOT LISTED ON THIS FORM THAT CARE/TREATMENT WILL BE DENIED AND THE MINOR'S APPOINTMENT WILL HAVE TO BE RESCHEDULED.

SIGNATURE: _____

DATE: _____