Southfield Kids Dentist, PLLC
17550 W. 11 Mile Rd. SUITE B
Lathrup Village, MI 48076
Office: (248) 565 – 3332
Fax: (248) 552 - 0992

AUTHORIZATION FOR OTHERS TO CONSENT TO DENTAL CARE

I hereby give permission for the following person:

First and Last Name:_____

Relationship to Child:_____

To bring my child into Southfield Kids Dentist for dental care. This includes but is not limited to: examinations, dental cleanings, fluoride treatments, x-rays, and restorative care. He or she also has my authorization to make any decision based on Doctor's or their Associate's recommendation(s) regarding treatment in my absence. I agree to assume financial responsibility for his and/or her decisions at that time.

This consent is valid from date signed until revoked by parent or legal guardian.

This consent is valid for the children listed below:

Child's First and Last Name	Child's Date of Birth

Signature:_____ Date:_____