



I authorize _____ (name and relation of person accompanying child) to accompany my child, _____, to his/her dental appointment. I agree to the following treatment to be performed in my absence:

- Examination
- Radiographs (x-rays) deemed necessary by Dr. Gazori
- Cleaning
- Fluoride
- Necessary restoration of decayed teeth
- Extractions
- Emergency treatment as necessary

I request that I be contacted at the phone number below if treatment needs or recommendations change during treatment.

If treatment recommendations change during treatment and I am not able to be reached I authorize the person accompanying my child to make an informed decision and authorize Dr. Gazori to perform the recommended treatment.

Phone number: _____

Parent/Legal Guardian Name: _____

Signature: _____

Date: _____