Accompany Minor Consent

Patient Name:____ Date of Birth:________________________

Patient Name:____ Date of Birth:________________________

Patient Name:____ Date of Birth:________________________

The following individuals may accompany and/or authorize dental treatment for this minor patient, and act on my behalf as indicated below (persons must be over 18 years old).
*Duke City Pediatric Dentistry reserves the right to postpone delivery of treatment in certain cases when the legal guardian is not present.

Name	Relationship to Patient

____ _____________________________ ___________________
Parent/Legal Guardian Signature Relationship to Child Date