Power of Consent Form

Parent or Legal Guardian (step parents also need authorization):
First name_____ Last Name _____

I, the parent or legal guardian of the child(ren) listed below, authorize the individuals below to accompany my child(ren) to dental visits and consent to necessary dental exams and/or treatment as well as disclosure of dental information regarding the initial and/or follow up care of my child(ren) during the visits.

Name of Child(ren): _____

Name/Relation of person bringing child other than parent:

Full Name _____Relationship to child_____

Full Name _____Relationship to child_____

Full Name _____Relationship to child_____

Full Name _____Relationship to child_____

The person(s) named above may consent to the examinations and treatment of my child with the office of Dr. Jacob E Myers, DDS, PLLC.

This authorization is effective on this _____(day) of _____(month)of _____(year).

This document is effective until revoked by me in writing to the office of Dr. Jacob E Myers DDS, PLLC.

Signature of parent/legal guardian_____ Date_____

Printed name of parent/legal guardian_____