

(516) 547-1997
1756A Merrick Avenue
Merrick, New York 11566



Office Hours
Mon & Wed: 10am - 6pm
Tue, Thu & Fri: 9am - 5pm
Sat: 9am - 2pm (1st and 3rd of month)
Sun: Closed

AUTHORIZATION FOR MINOR CHILD ACCOMPANY

Child(ren)'s full name (s): _____

DOB (s): _____

I, _____ give _____

(Parent or Legal Guardian) (Authorized Person's Full Name)

Permission to accompany my child to the office of Merrick Pediatric Dentistry for dental appointments.

I also give permission to _____ to make necessary decisions

(Authorized Person's Full Name)

regarding dental treatment for my child including, but not limited to:

- The consent for this authorized person to accompany my child for exams, dental cleanings or restorative treatment and to discuss post-operative instructions.
- The consent of Merrick Pediatric Dentistry to discuss finances (treatment charges, account balances, next visit charges) with this authorized person.
- The consent for this authorized person to discuss my child's dental findings, future dental treatment needs and any pertinent personal health information (PHI).

As the parent or legal guardian, I understand that I must present to the office, in person, to sign any treatment plans or informed consents before any restorative procedures or invasive dental treatment can be performed for my child. I further understand that it is my responsibility to provide payment or a source of payment on the day that services are rendered, even when this authorized person brings the child, or no treatment will be performed for my child.

Signature of Parent (legal Guardian)

Date

Merrick Pediatric Dentistry Representative

Date