Disclosure of Information

I, _____ (parent/legal guardian) authorize the following people to bring any of the children listed as Kingwood Pediatric Dentistry's patients to bring them to their dental visits. I consent for them to make decisions for their dental visit and in the case of an emergency. I understand that the responsible party will still be responsible for all costs of treatment. Must be 18 years old or older and be able to provide identification upon arrival.

Patient Name: _____

Patient Name: _____

Patient Name: _____

Patient Name: _____

Authorized person:

Name: _____ Birthdate: _____Relationship: _____

Name: _____ Birthdate: _____Relationship: _____

Name: _____ Birthdate: _____Relationship: _____

Name: _____ Birthdate: _____Relationship: _____

Date: _____

Patient/ Parent/ Guardian Signature: _____

Relationship to Patient: _____