RYAN DENTAL Group

Authorization for Medical Treatment of Minors

Completion of this form allows an adult (other than the parent or guardian) to give consent and obtain medical treatment for a child (under age 18). The adult must be at least 18 years old.

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

I/We, the parent(s) or legal guardian(s) of the above named minor(s), do hereby appoint:

Name _____ Address _____

Phone Number _____ Relationship to Patient _____

Name _____ Address _____

Phone Number _____ Relationship to Patient _____

To act on my/our behalf in authorizing medical, dental, surgical care and hospitalization for the above named minor(s) during the period of my/our absence, from the dates of:

_____ to _____.

The 2nd blank above may say "until permission is revoked" rather than a specific date

FINANCIAL RESPONSIBILITY

I/We understand that payment is expected at the time of services, and will insure that the above mentioned appointed caretaker has the required insurance information, and the means to pay the necessary fees at the time of service. I/We accept full responsibility for the charges accrued in the healthcare of my/our children if the physician, dentist, hospital, or other ancillary healthcare provider is unable to collect from my/our insurance company.

_____ _____ _____

Signature Parent/Legal Guardian Printed Name Parent/Guardian Date

720 E. Main Street, Suite A, Allen, TX 75002 Phone: 972-727-5001 Fax: 214-644-0077

Office@RDGAllen.com www.RDGAllen.com