PERMISSION TO ACCOMPANY A MINOR

I, _____, give permission to _____
(Name of Parent/Guardian) (Name of adult to be accompanying child)

to accompany my child _____ and authorize treatment for my
(child's name and DOB)
child inaccordance with the office policy of McCartney Dental. This includes bringing the child into the office of McCartney Dental, providing a history of present illness, disclosing protected health information. This adult has the responsibility to relay any diagnosis, treatment plan or prescription(s) to the parent or legal guardian mentioned above.

I agree to be available by phone at: _____and to be financially responsible for all copays and coinsurance.

I DO_____DO NOT_____ authorize the person stated above, to make, change, or cancel any appointments for this minor patient.

Child's Health Information
Current prescribed or over-the-counter medications and dosages:

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Allergies, illnesses or other comments: _____
_____

Emergency Contact Information:
Person to be contacted in case of emergency?
Parent/Guardian
Name: _____Phone: _____
Relation: _____
Parent/Guardian:
Name: _____Phone: _____
Relation: _____

Health Insurance Information❒No change since last visit *(skip to next section)*
Insurance Company:_____ Policy Holder: _____
ID Number: _____ Group Number: _____
Effective Date: _____ Copay: _____

Parent/Guardian Name (Printed):_____

Parent/Guardian Name (Signature):_____Date:_____