I authorize ____ (name and relation of person accompanying child) to accompany my child, ______________________________, to his/her dental appointment. I agree to the following treatment to be performed in my absence:

- □ Examination
- □ Radiographs (x-rays) deemed necessary by Dr. Pacella
- □ Cleaning
- □ Fluoride
- □ Necessary restoration of decayed teeth
- □ Extractions
- □ Emergency treatment as necessary
- □ I request that I be contacted at the phone number below if treatment needs or recommendations change during treatment.

If treatment recommendations change during treatment and I am not able to be reached I authorize the person accompanying my child to make an informed decision and authorize Dr. Pacella to perform the recommended treatment.

Phone number: _________________________

Parent/Legal Guardian Name:___________________________________

Signature:______________________________________

Date: __________