

KEARNS & ASHBY, D.D.S., P.C.

CHILDREN'S AND ADOLESCENT'S DENTISTRY

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POWER OF CONSENT FORM

I, _____ (Name of Parent or Legal Guardian),

designate _____
Name of Person Bringing Child for Care

to consent to necessary dental treatment for the following child:

_____, born on _____.

The power that I confer is specifically limited to dental health care decision-making and verification of patient demographic and insurance information, and it may be exercised only by the person named above.

The person named above may consent to the examinations and treatment for my child with Dr. Kearns, Ashby, Rajchel or Kearns.

I confer the power to consent freely and knowingly in order to provide for the child and not as a result of pressure, threats or payments by any person or agency. This document shall remain in effect, as noted above, or until it is revoked by my written notification to my child's dental and insurance providers, and the person named above.

In witness whereof, I have signed my name to this dental consent authorization, on this

_____ day of _____, 200__.

(Printed Name) _____ (Signature) _____

(Witness Signature) _____

(Signature of Person to whom Power to Consent is being given) _____