Dentistry for Children & Adolescents, Ltd.

Dr. Robyn R. Loewen
Dr. Kala L. Hinz

PERMISSION FORM

I, _____, mother/father/legal guardian give permission to the staff of Dentistry For Children and Adolescents, Ltd. to communicate with the following person:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

regarding appointments, treatment planning and financial arrangements for the below named patient:

_____.
Patient's name

_____.
Patient's name

_____.
Patient's name

Signature of parent/legal guardian:_____

Address:_____

Daytime phone numbers: _____ _____

Parent/Guardian Email Address: _____

Date:_____

(This permission is valid unless revoked by legal guardian or Dentistry for Children and Adolescents, Ltd.)

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