Advantage Dental
From DentaQuest

AUTHORIZATION TO CARE FOR A MINOR

TO BE COMPLETED BY THE MEMBERS AUTHORIZED REPRESENTATIVE

I, _____, am the _____ of the following named minor(s)
(Print Your Full Legal Name) (relationship to minor(s))

_____
(List Minor's Full Legal Name) (Social Security No.) (Date of Birth)

_____
(List Minor's Full Legal Name) (Social Security No.) (Date of Birth)

_____
(List Minor's Full Legal Name) (Social Security No.) (Date of Birth)

I am the legal guardian/custodial parent of the minor(s) named above and I have the authority to make healthcare decisions and authorize treatments for the minor(s) listed above. In my absence, I grant and authorize the following people the right and power to bring the minor to the dental clinic for services, to make healthcare decisions, and to authorize treatment(s) as recommended by the minor's dentist:

_____
(Authorized Person's Full Name) (Relationship to Minor)

_____
(Authorized Person's Full Name) (Relationship to Minor)

_____
(Authorized Person's Full Name) (Relationship to Minor)

I authorize and grant the people described above the power to sign any consent forms, releases, waivers, and any other forms required by Advantage on my behalf to proceed with the dental treatment as recommended by the minor's dentist. By signing below, I agree to pay for and be responsible for any services/treatments authorized in my absence. I understand that this authorization is effective until I cancel it by giving Advantage written notice or until I amend this form by completing a new form.

_____ _____
Signature of Guardian/Custodial Parent Date

_____ _____
Print Your Full Legal Name Relationship to Minor(s)

_____
Witnessed by

To Improve the Oral Health of All
www.AdvantageDentalClinics.com
442 SW Umatilla Avenue Redmond, OR 97756 | TEL: 866.468.0022 | FAX: 866.268.9618