Foster City Dental Care
675 Mariner's Island Blvd., Suite #110
San Mateo, CA 94404
Phone: (650) 577-1988 FAX (650) 577-0835

AUTHORIZATION FOR A CARE-TAKER TO ACCOMPANY A MINOR TO DENTAL APPOINTMENTS

Minor Child's Name (First, MI, Last): ______________________________

Name of Parent/Legal Guardian (First, MI, Last): ______________________________

I authorize the care-takers listed below to bring my minor child (named above) to FOSTER CITY DENTAL CARE for scheduled appointments for treatment in which I have previously been notified of and have consented to on my minor child's behalf.

Please be sure to list those that will most likely, other than yourself, bring your child to their appointments at FOSTER CITY DENTAL CARE. Include relatives, step-parents, siblings, baby-sitters/nannies, friends and significant others.

____________________ ____________________ ____________________

____________________ ____________________ ____________________

I understand this authorization for a care-taker to accompany my minor child to appointments does not permit the care-taker to consent to treatment and that only a parent/legal guardian may consent to treatment for my minor child. If there is a change in treatment at the appointment in which a care-taker is accompanying my minor child and it has not been previously diagnosed, explained to me and authorized by me, every effort will be made to contact me prior to proceeding with the treatment. If I cannot be reached to provide verbal treatment consent, I understand the treatment will not be performed and that charges for the visit may still apply.

Following is the best number to reach me at: ______________________________

I further understand that all consents and health updates needed by FOSTER CITY DENTAL CARE must be completed in advance when a care-taker is accompanying my minor child to their dental appointment. Additionally I accept responsibility for all incurred charges, including verbally authorized changes in treatment, and will arrange for payment in advance or on the day of service to meet my financial responsibilities.

I understand that this authorization will remain in effect until FOSTER CITY DENTAL CARE is otherwise notified of any change in the status of any of the above designated care-takers. I understand that it is my responsibility, as the parent/legal guardian, to inform FOSTER CITY DENTAL CARE of any change to this authorization.

______________________________ ____________________
Parent/Legal Guardian Signature Date