J. Mark Bayless D.M.D., Inc.
Brandi Faia D.D.S.

Authorization for Third Party Consent for Treatment of Minor

My child, ________________________________, will not be accompanied by a parent/legal guardian for his/her appointment. I hereby authorize ________________________________ to accompany my child to his/her dental appointment(s) and to give them permission to consent to dental treatment for my child on my behalf to perform any necessary dental treatment needed, including, but not limited to, a comprehensive examination, diagnostic radiographs, and a fluoride varnish treatment by Dr. J. Mark Bayless and/or Dr. Brandi Faia.

In the event of an emergency, Dr..J. Mark Bayless and/or Dr. Brandi Faia and staff have my permission to take any and all necessary steps to ensure the safety and well being of my child.

____ _______________________

Parent/Legal guardian Signature **Date**

□ *No changes with patient's medical history.*

□ *Yes, the patient has the following changes with his/her medical history:*

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