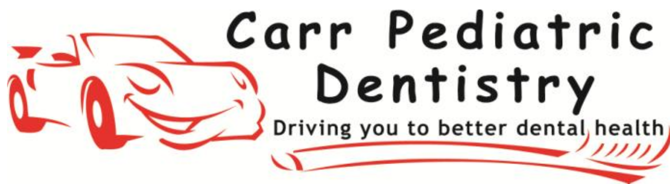

Dr. Natalie Carr
11936 Boyette Road
Riverview, Florida 33569
Phone: (813) 672-3368
Fax: (813) 672-3398

AUTHORIZATION – DENTAL CARE OF A MINOR PARENT NOT PRESENT

Patient: ____

Patient Date of Birth: __________________

Person(s) I authorize to accompany my child:

Name _________________________ Relationship to child: ______________

Name _________________________ Relationship to child: ______________

Name _________________________ Relationship to child: ______________

I authorize Dr. Natalie J. Carr, DDS, MS and such assistants as she may designate, to render dental care to my child. I consent to any dental care which encompasses diagnostic or dental treatment which my dentist or her designee may deem necessary for my child's dental health and well-being.

This authorization will remain effective unless terminated by written notice.

Phone number where parent can be contacted during treatment, if needed:

Cell phone number: ___________________________

Work phone number: ___________________________

__________________________________ ____________________
Signature of Parent or Legal Representative Date

____
Relationship to Patient

_________________________________ ____________________
Witness Date