Dental Specialists for Children & Teenagers
125 Siegler Street • Green Bay, WI 54303 • 920-592-8940
Dr. Eric Van Miller • Dr. Meredith Evans • Dr. Stephanie Pagels

PATIENT INFORMATION AUTHORIZATION

This form is to be completed for any other person bringing the child/children in for their dental appointments other than the natural mother or father or legal guardian.

Account Number _____

Patient Name_____ Birthdate_____
Patient Name_____ Birthdate_____
Patient Name_____ Birthdate_____
Patient Name_____ Birthdate_____

I give permission to Park-West Pediatric Dental Associates, Ltd. to release or discuss any information regarding the dental visit to the people indicated below. I authorize the individuals below to consent to dental treatment for the patients listed above.

1._____ _____
(Print Name) (Relationship to patient)

2._____ _____
(Print Name) (Relationship to patient)

3._____ _____
(Print Name) (Relationship to patient)

Date_____ Signature_____
(Natural mother or father or legal guardian)

This authorization will remain in effect until it is revoked in writing by the natural mother or father or legal guardian listed above.