DR. MELISSA M. BEAUDET-UY
GENERAL DENTISTRY LIMITED TO CHILDREN AND TEENS

MELISSA M. BEAUDET-UY D.D.S.

Hillside Plaza
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POWER OF CONSENT FORM

I, _____ the parent or legal guardian of
(Name of Parent of Legal guardian)

_____, authorize the individuals below
(Name of Child(ren))

to accompany my child(ren) to visits and consent to necessary dental exams and/or treatment and disclosure of dental information regarding the initial and/or follow-up care of my child(ren) during the visits.

_____ _____
(Name of person bringing child other than a parent) (Relationship to child)

_____ _____
(Name of person bringing child other than a parent) (Relationship to child)

_____ _____
(Name of person bringing child other than a parent) (Relationship to child)

The person named above may consent to the examinations and treatment for my child with Dr. Beaudet-Uy.

This authorization/consent is effective on this,

_____ day of _____, 20___, in. This document is effective until revoked by me in writing to Dr. Beaudet-Uy.

_____ _____
(Signature of Parent/Legal Guardian) (Printed Name of Parent/Legal Guardian)