Authorization to See Minor

Please fill this form out prior to your child/children's dental appointment. We will need to have one of these completed forms on file for each of their dental visits.

I authorize Dr. Darren L. Flowers and his staff to perform planned dental treatment on my minor child/children name(s): _____

_____

Appointment Date: _____ Appointment Time: _____

At the appointment time I can be reached at _____

If any changes occur in the treatment the parent/guardian will be notified. If we are unable to contact the parent/guardian, the Doctor and/or staff will use their best judgment in proceeding.

Date: _____

_____
Parent/Guardian Name

_____
Parent/Guardian Signature

Darren L. Flowers, D.M.D., Anthem Medical Plaza, 3618 W. Anthem Way, D132, Anthem, AZ 85086 623-551-8000