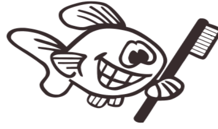

Dentistry for Children

James M. Hori, D.D.S.

Letter of Authorization

I, _________________________________ give full authorization to _________________________________
Parent/Guardian name (please print) Accompanying party (please print)
whose relationship is_____________________________________ to accompany my child/children to all future
Relationship to patient (please print)
appointments. I understand that the above mentioned is able to schedule appointments and make decisions in my absence regarding my child's treatment. In the event that the original diagnosis is changed, I have provided a contact number ______________________ so that I may be alerted via phone as well. I understand that the accompanying
Contact number (please print)
party will also be responsible to pay for services rendered on the appointment day and I will provide sufficient notice prior to the appointment.

Signature: ____________________________________ Date:_____________
Parent/Guardian Signature

Patient: ____
Patient name (please print)

Patient: ____
Patient name (please print)

Patient: ____
Patient name (please print)

Patient: ____
Patient name (please print)

Patient: ____
Patient name (please print)

94-229 Waipahu Depot Street Suite 501 Waipahu, HI 96797
Phone (808) 670-0055 Fax: (808) 671-3443
www.jhoridds.com