James Hori, D.D.S
Dentistry for Children
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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
Relationship to patient (please print)

all future 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 _____
Contact number (please print)

so that I may be alerted via phone as well. I understand that the accompanying party will also be responsible to pay for services rendered on the appointment day and I will provide sufficient notice prior to the appointment.

Patient: _____ Date:_____

Patient: _____

Patient: _____

Patient: _____