Proxy Form

Patient's Name: _____

Name of Person Completing this Form: _____

Relationship to the Patient: _____

If you don't want to authorize an additional person to make medical/dental treatment decisions & bring your child to his/her appointment, please write a check near the statement below.

_____ I don't authorize an additional person to make medical/dental treatment decisions or bring my child to his/her appointment.

If you would like for an additional person or people to make medical/dental treatment decisions & bring your child to an appointment please complete the rest of this form.

I authorize the following people to make medical/dental treatment decisions & bring my child to his/her appointments.

1) Person's full name:_____
   Person's relationship to child: _____
   Person's phone number:_____

2) Person's full name:_____
   Person's relationship to patient:_____
   Person's phone number:_____

Signature:_____

Date:_____