MICHAEL P. MARFORI, D.M.D.
PEDIATRIC DENTISTRY

Child's Name: ____ Date of Birth: _______________
Child's Name: ____ Date of Birth: _______________
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Permission form for adults other than the parents or legal guardians to bring the child(ren) to the office for medical care, and to give consent for medical treatment.

The purpose of this form is to allow you, the parent, the option of naming other adults to bring your child to the office of Michael Marfori, DMD for dental evaluation and treatment. You will be giving permission for these adults to discuss your child's personal medical history with the staff of Dr. Marfori as needed and to make medical decisions for you regarding the dental care of your child.

If there are no adults listed, then your child will only be seen when brought by the parent or legal guardian.

Date	Parent's Initial	Name of Adult	Relationship to Child(ren)

This form may be modified in writing at any time at the request of either parent. To remove an adult from this list, please notify one of Dr. Marfori's office staff.

____ ____________________________
Print name of Parent/Legal Guardian Relationship to child(ren)

____ ____________________________
Signature Date