**Appointment Consent- Proxy Consent to Treat Minor(s)**

**Please complete for person(s) other than legal guardian who has permission:**

I give **Naptown Smiles** consent for my child(ren) to be brought to their dental appointments by the following person(s) listed below. **Naptown Smiles** may share any information with the person(s) listed below regarding my child's dental needs.

NAME: ______________________ RELATIONSHIP TO CHILD: ______________________

NAME: ______________________ RELATIONSHIP TO CHILD: ______________________

The person(s) listed above can authorize any x-rays to be taken on my child(ren) or application of fluoride. ☐ **YES** ☐ **NO**

This person(s) listed above can schedule appointments or cancel appointments on my behalf. ☐ **YES** ☐ **NO**

This person(s) can accompany my child(ren) to treatment appointments and make decisions on their behalf. ☐ **YES** ☐ **NO**

Parent/ Legal Guardian Signature: __________________________ Date: ____________

Patient(s) Name: ______________________________