Dr. Duga Dr. Feeney & Associates
Pediatric Dentistry

Authorization – Dental Care of a Minor when a Parent is not present

Patient: _____

Patient Date of Birth: _____

Person(s) I authorize to accompany my child:

Name _____ Relationship to child: _____

Name _____ Relationship to child: _____

Name _____ Relationship to child: _____

I authorize Paul H. Duga, DDS, Shawna Adams-Feeney, DMD, and such assistants as he/she may designate, to render dental care to my child. I consent to any dental care which encompasses diagnostic or dental treatment which the dentist may deem necessary for my child's dental health and well-being.

This authorization will remain effective unless terminated by written notice.

Phone number where parent can be contacted during treatment, if needed:
Home: _____
Work: _____
Cell: _____

_____ _____
Signature of parent or legal representative Date

_____
Relationship to Patient

_____ _____
Witness Date