



“We Keep You Smiling”

AUTHORIZATION FOR AGENT TO CONSENT TO DENTAL TREATMENT OF A MINOR

I hereby authorize \_\_\_\_\_ (an adult into whose care the minor has been entrusted) to consent to any X-ray, examination, anesthetic, or dental diagnosis or treatment of \_\_\_\_\_ (name of minor) deemed advisable by a dentist or hygienist and provided by that dentist or hygienist or under that dentist's or hygienist's supervision regardless of where that treatment is provided. This authorization is made under California Family Code # 6910.

Signed : \_\_\_\_\_ Dated: \_\_\_\_\_

Printed name: \_\_\_\_\_

Please specify relationship to minor:  Parent with legal custody  
 Guardian with legal custody

**Forrest R. Boozer, D.D.S.**

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