# Authorization to See Minor

**Please fill this form out prior to your child/children's dental appointment. We will need to have one of these completed forms on file for each of their dental visits.**

I authorize Dr. Darren L. Flowers and his staff to perform planned dental treatment on my minor child/children name(s): _____

_____.

Appointment Date:_____ Appointment Time:_____

At the appointment time I can be reached at _____.

**If any changes occur in the treatment the parent/guardian will be notified. If we are unable to contact the parent/guardian, the Doctor and/or staff will use their best judgment in proceeding.**

Date:_____

_____
Parent/Guardian Name

_____
Parent/Guardian Signature