PARENTAL CONSENT FORM

AUTHORIZATION FOR TREATMENT OF MINOR CHILD

I, _____, parent/legal guardian of _____ _____, a minor child, authorize treatment by any provider of Dr. Michael P. Moriarty, P.C.

_____ _____

Signature of parent/legal guardian Date

AUTHORIZATION FOR TREATMENT OF MINOR CHILD – AUTHORIZED ADULT

For the child named above, I request that he/she be allowed to be seen by any provider of Dr. Michael P. Moriarty, P.C., if accompanied by the following named adult(s):

Name _____ Name _____

Relationship _____ Relationship _____

_____ _____

Signature of parent/legal guardian Date

AUTHORIZATION FOR TREATMENT OF MINOR CHILD-ABSENCE

For the child named above, I request that he/she be allowed to be seen by any provider of Dr. Michael P. Moriarty, P.C., without parent/legal guardian present. I understand that the dentist/hygienist always has the option to refuse service if he/she feels it is in the minor's best interest that I am present. ***I further agree to be available by phone if needed during the appointment time.***

_____ _____

Signature of parent/legal guardian Date

I agree to be fully and completely financially responsible for all incurred charges. This authorization is effective until the minor whose name is listed above becomes an adult or that I notify Dr. Michael P. Moriarty, P.C., in writing of any change.

_____ _____

Signature of parent/legal guardian Date

_____ _____

Contact Phone Numbers –home/work/cell DOB parent/legal guardian