KENT ISLAND PEDIATRIC DENTISTRY

Account Contact Information

Main contact- Primary person to confirm and receive appointment reminders

Cell Ph.: (_____)_____ Secondary Ph.: (_____)_____

Current Mailing Address: _____

Email address: _____

Back-up Contact- We require two phone numbers to confirm appts.

Cell Ph.: (_____)_____ Secondary Ph.: (_____)_____

I give consent for **Kent Island Pediatric Dentistry** to leave detailed voicemails on my main contact regarding my child (ren) dental visit or dental insurance. _____ YES _____ NO

Appointment Consent- Proxy Consent to Treat Minor(s)

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

I give **Kent Island Pediatric Dentistry** consent for my child (ren) to be brought to their dental appointments by the following person(s) listed below. **Kent Island Pediatric Dentistry** may share any information with 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

_____ Date:_____

Parent/Legal Guardian Signature- Relationship to Patient

Patient (s) Name:_____