MORRISON DENTAL ASSOCIATES
6602 Abercorn St. Suite 101, Savannah, GA 31405 Phone (912)354-3444 Fax (912)354-5074
207 East 31st St. Savannah, GA 31401 Phone (912)232-2779 Fax (912)236-7110

I_____, parent of
Parent's Name

_____
Patient who is under the age of 18

authorize _____
Name of Temporary Guardian

who is over the age of 18 years and related to the patient as _____
Relationship to patient

to authorize all dental treatment for the patient. I understand that I am responsible for all charges authorized by this individual and that payment for such treatment is due at the time it is provided.

I understand that Morrison Dental Associates, P.C. doctors and staff will provide treatment authorized by the above name individual as if it were authorized by you, the parent. The individual named above will be responsible for notifying Morrison Dental Associates, P. C. doctors and staff of any medical problems which the patient may be experiencing which would preclude the patient from having dental treatment. The individual named above is responsible for being aware of any dental treatment which you, the parent, do not want provided and it is that individual's responsibility to communicate such information to the doctors and staff of Morrison Dental Associates, P.C.

_____ _____
Signature of Parent Date

_____
Printed Name of Parent

_____ _____
Signature of Witness Date

_____
Printed Name of Witness