

East Side Pediatric Dental
133 East 58th St., Suite 402
New York, N.Y.10022

I, _____ (Parent or Legal Guardian)

hereby, authorize (Assignee/must be over 18 years) :

1. _____ relationship: _____
2. _____ relationship: _____
3. _____ relationship: _____
4. _____ relationship: _____

to bring my child(ren) _____ to East Side Pediatric
Dental for his/her dental appointment(s). Please call me at the following phone
number if any treatment/s has or will change to discuss.

Signature of Parent or Legal Guardian

Phone number

Relationship to Patient

Date