Cochran, Soares, and Associates

Pediatric Dentistry

Stephen D Cochran, DMD | Flavio M Soares, DDS | Jacqueline M Fetner, DMD

All are Diplomats of the American Board of Pediatric Dentistry

CONSENT TO ACCOMPANY A MINOR CHILD

Patient Name(s):		Date(s) of Birth:	

I, _____ , give permission to _____

(PARENT OR LEGAL GUARDIAN) (PERSON(S) TO ACCOMPANY PATIENT)

to accompany my child to Pediatric Dentistry for dental appointments.

I also give permission to the person(s) named above to make any necessary decisions regarding dental treatment for my child, including but not limited to:

- The consent for this authorized person(s) to sign any and all forms required to give permission to Pediatric Dentistry to treat the dental needs of my child on the day of service and to discuss the needs and sign any forms pertaining to the future dental treatment needs (ie: treatment plans, consent forms, health history forms) of my child

- The consent for this authorized person(s) to discuss treatment recommended, go over my child's dental needs and prevented care and post op instruction, detalls on procedures with the Doctors, Clinical Staff, or Administration Staff for my child

- The consent to the dental practice to discuss any account Information and finances (details on account, treatment charges, accounts balances, next visits charges, insurance Information) with this authorized person(s) and for this person to schedule any future dental visits for my child

I UNDERSTAND THIS CONSENT WILL BE VALID FOR ONE YEAR OR UNTIL I RESCIND THIS AGREEMENT IN WRITING.

Signature: _____ Date: _____

(PARENT OR RESPONSIBLE PARTY)

BAYMEADOWS OFFICE 8355 Bayberry Road, Jacksonville, FL 32256
ST. JOHNS PARKWAY OFFICE 2050 St. Johns Parkway, Suite 103-104, St. Johns, FL 32259

(904) 733-7254 • office@setzerandcochran.com • cochranandsoares.com