



I \_\_\_\_\_ do authorize dental care for my child  
\_\_\_\_\_ to be completed by Progressive Family &  
Cosmetic Dentistry. He/She may receive all necessary dental care warranted for this visit  
\_\_\_\_\_ ; including fluoride and x-rays.  
*Date of Service*

Please include updated insurance information, allergies, current medications that he/she are taking and any illnesses.

List (2) two contacts to be reached in case of an emergency include; name, address and phone number.

---

---

---

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*