Proxy Consent to Treat a Minor

This form is to allow a legal adult other than a parent or legal guardian to serve as a proxy decision maker for dental care services at A Smile 4U.

To appoint a proxy decision maker, please review and complete the following form authorizing dental treatment and/or services of a minor child.

_____ _____
Minor Child's Name D.O.B.

Authorization—I hereby appoint:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I hereby indemnify and hold harmless A Smile 4 U, LLC, and its officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization. The individual(s) appointed as proxy (listed above) is/are permitted to make decisions or consent to the care of the minor child in my absence. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization is valid for one year (1) following the date signed below unless withdrawn in writing to A Smile 4 U, LLC or restricted by time frame as noted above. I agree it is my responsibility to update this proxy consent with any changes.

Only one parent's signature is required.

_____ _____
Print Name of Parent or Legal Guardian Date

_____ _____
Signature of Parent or Legal Guardian Date