

POWER OF ATTORNEY

I, _____, _____,
Name of Parent or legal guardian Relationship to Patient

Give my permission and authority to _____,
Name of accompanying adult

_____ to bring _____
Relationship to Patient Patient's Name

for dental treatment by Dr. Drum and his staff on

date(s) _____ and make any and all decisions

related to that treatment that may be necessary. I will be legally bound by any decisions

made by _____ as if they were my decisions.
Name of accompanying adult

Signature _____ Date _____

Printed Name: _____

Witness: Signature _____ Date _____

Printed Name: _____