Gerald K. Weaver, D.M.D.
Michael W. Stratton, D.M.D.
Robert V. Weaver, D.M.D.
J. Patrick Weaver, D.M.D.
Aylin Mazzuoccolo, D.M.D.
Anna Sipe, D.D.S.
Nikki Darbani, D.D.S.

# PATIENT ESCORT FORM

Today's Date:________________________

Patient Name:____________________________________DOB:___/___/ _____

I, authorize_________________________________________ to escort my child to his/her dental appointments and allow this escort to provide consent for any necessary dental treatment.

Furthermore, I authorize Weaver and Stratton Pediatric Dentistry staff to examine the patient, clean his/her teeth, take dental radiographs, perform any necessary dental treatment, administer local anesthetic if recommended, administer medications, and apply topical fluoride.

Escort Name: ______________________________________________________

Relationship to Patient: _____________________________________________

Parent/Legal Guardian: _____________________________________________
(print name)

Parent/Legal Guardian: _____________________________________________
(signature)

Parent's Contact Phone Number: _____________________________________

Other Notes: ______________________________________________________
_________________________________________________________________
_________________________________________________________________