WEAVER & STRATTON
PEDIATRIC DENTISTRY

GERALD K. WEAVER, D.M.D.
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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: _____

_____

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