Tina P. Moses, DMD, PC

Pediatric Dentistry

1240 Augusta West Pkwy • Augusta, Georgia 30909
Phone: 706-863-6262 • Fax: 706-863-6465

PERMISSION FORM

Please print all information clearly. Please include area code with all phone numbers.

CHILD'S NAME____

CHILD'S NAME____

CHILD'S NAME____

I, ______________________________, given the individuals listed below permission to bring my child(ren) to their dental visits and authorize Tina P. Moses, DMD, PC to give them any information regarding dental care for my child(ren). They have full authority to make any dental and financial decisions for my child(ren), including but not limited to radiographs, fluoride treatments, nitrous oxide, and sedation. I understand that payment for services rendered is due at the time of treatment and agree to make payment arrangements if the individual accompanying my child(ren) is not prepared to make payment in full. Tina P. Moses, DMD, PC will make every effort to keep the accompanying adult informed before treatment is changed, however we realize that this may not always be possible and the adult will be informed of any changes at the completion of the appointment. I understand that if I need to make any changes to this agreement I must do so in writing.

NAME	PHONE NUMBER(S)	RELATIONSHIP TO PATIENT
1.		
2.		
3.		
4.		
5.		

Payment for services is due in full at the time of treatment unless prior arrangements have been made.
If this account should go to collections, you will be responsible for all collection fees and any attorney fees.

______________________ Signature

______________ Date

______________________ Relationship to Child