

Pediatric Dentistry
John W. Bishop, D.D.S.*
Carlos A. Bertot, D.M.D.*



Orthodontics
John R. Smith, D.D.S., M.S.D.

Pediatric Dentistry of Central Florida
BISHOP • BERTOT

Child's Name _____

Date of Birth _____

Permission form for adults other than the parents or legal guardians to bring the child to the office for medical care, and to give consent for medical treatment.

The purpose of this form is to allow you, the parent, the option of naming other adults to bring your child to the office of John W. Bishop, D.D.S., Carlos A. Bertot, D.M.D., or Eric Berry, D.M.D. for dental evaluation and treatment. You will be giving permission for these adults to discuss your child's personal medical history with the staff of Dr. Bishop, Dr. Bertot, and Dr. Berry as needed and to make medical decisions for you regarding the dental care of your child.

If there are no adults listed, then your child will only be seen when brought by the parent or Legal Guardian.

Date	Parent's Signed Initial	Name of Adult	Relationship to Child	Date & sign here ONLY when Removing Permission

This form may be modified in writing at any time at the request of either parent. To remove an adult from this list, simply draw a line through the adult's name, sign your own name and date the time that you make the change in the column to the right.

Print name of parent or Guardian

Relationship to child

Signature

Date