South Tampa Pediatric Dentistry

Lesley Rudolph, DMD
Diplomate, American Board of Pediatric Dentistry

AUTHORIZATION - CARE OF A MINOR (DENTAL)

Patient:_____ Date:_____

Patient Date of Birth: _____

I authorize Dr. Lesley Rudolph and associated dental practitioner and such assistants as he/she may designate, to render dental care to

_____.

I consent to any dental care which encompasses diagnostic or dental treatment which my dentist or his/her designee may deem necessary for my child's dental health and well-being.

_____ _____
Signature of Parent or Legal Representative Date

_____
Relationship to Patient

Notarization:

State of Florida
County of Hillsborough
The forgoing instrument was acknowledged before me, by means of ☐ physical presence or ☐ online notarization, this____ day of ____, 20___, by_____.

Signature of Notary_____
Printed Name of Notary _____

Personally Known _____ OR Produced Identification _____
Type of Identification_____