Justin Family Dentistry
"A true Family Practice"

AUTHORIZATION FORM

I, _____ authorize the following people

to discuss dental treatment for _____.

1. _____ Relationship to Patient _____
2. _____ Relationship to Patient _____
3. _____ Relationship to Patient _____
4. _____ Relationship to Patient _____

Signature _____ Date _____

Relationship to Patient _____

NOTE: PHOTO ID IS REQUIRED FOR EACH PERSON AT THE TIME OF THE VISIT.