Debra V. Irvin, DDS, PC
5201 N. Broad St.
Phila., PA 19141-1627 215-329-5512

AUTHORIZATION FOR SUBSEQUENT VISITS OF AN ADOLESCENT

Parent/Guardian must be present during the first visit to the office

I/we, the parent(s) and / or legal guardian(s) of _____
(Name of child 13 years of age or older)

hereby permit him/her to come on his/her own to the dental office of Dr. Debra V. Irvin for the evaluation and treatment of dental diseases. Evaluation and treatments may include but are not limited to examinations, images (xrays) the giving of prescriptions for medications when necessary, cleanings, fillings, local anesthesia and the removal of sutures.

I/we will be informed of any special concerns noted during treatment. Similarly, I/we will inform the dentist of any special concerns that I/we may have regarding my/our child.

I/we have had an opportunity to ask questions regarding this authorization and have had my/our questions answered to my/our satisfaction.

This authorization:

_____ is good only on this date_____.

_____ is good from this date _____ to this date _____.

_____ is good until cancelled by me/us in writing or in person.

I/we have the right to cancel this permission at any time in person or by writing to Dr. Irvin.

Date	**Print Name of Parent/Guardian**	**Signature of Parent/Guardian**
	Print Name of Parent/Guardian	**Signature of Parent/Guardian**
	Print Name of Dental Office Witness	**Signature of Dental Office Witness**