KOOL KIDZ
DENTIST & ORTHODONTICS

18 Rancho Camino Dr. Suite 104 Pomona, CA 91766 – (909)622-7444 – Fax (909)622-0550

# Chaperone Consent Form

Patient Name: _____ Date:_____

Patient's Birth Date: _____

In my absence I hereby give authorization for the person listed below to bring my child(ren) to Kool Kidz Dentist and Orthodontics. I give my consent to all diagnostic aids including x-rays, photographs, recommended dental services, and update the patient's health history. A legal guardian must bring the child to the first dental appointment.

Chaperone Name: _____

Chaperone Phone Number: _____

Chaperone Date of Birth (must be 21 or older) _____

Relationship to Minor: _____

Chaperone Signature: _____ Date: _____

This consent will remain in effect for 90 days or until changes are made by the parent/guardian as signed below.

Parent/Guardian Acknowledgement/Acceptance: I agree to pay at the time services are rendered. The Patient's Health History form must be completed and attached with the chaperone consent. Please note **picture ID** will be needed on the day of service. This consent is only honored for 90 days or until changes are made by the parent/legal guardian as signed below.

_____ _____

Printed Name Parent/ Legal Guardian Phone Number

_____ _____

Signature of Parent/ Legal Guardian Date