Aiea Pediatric Dental Center
Dr. Derek B. Tom, D.D.S.
Dr. Lauren J. M. Imai, D.D.S., M.S.

Letter of Authorization to Accompany Patient

I,____ , give authorization for my child/children:

____

____

____

to be accompanied to any dental appointments by the following person/persons:

___________________________ - Relationship to pt____________

___________________________ - Relationship to pt____________

___________________________- Relationship to pt____________

I understand that this means that the above mentioned will be able to make any decisions regarding my child/children in my absence. I understand that if I am expected to pay for services on the day of the appointment I will make sure that the accompanying party will be able to fulfill my obligation and I will make them aware of the circumstances involved. I also give authorization for the above mentioned to:

Schedule future appointments
Fill out/Sign forms

_______________________________________ ___________
Signature Date