DENTAL POWER OF ATTORNEY (DPOW)

THIS DPOW ALLOWS ABSENTEE PARENTS TO TEMPORARILY DESIGNATE AND ALLOW SURROGATES TO ACT ON THEIR BEHALF WHILE ALLOWING DENTAL TREATMENT TO BE RENDERED IN THIS FACILITY TO THEIR CHILD(REN) AND TO ASSIGN HOW MEDICAL EMERGENCY SHOULD BE ADDRESSED SHOULD IT BE NEEDED.

We_____(parent) and _____(parent) hereby grant, _____(surrogate) of _____(address) (attach copy of driver's license) authority to obtain dental treatment for the following child(ren):

1._____ 2._____

The above name surrogate (care provider with driver's license), is authorized to:
- obtain dental treatment and procedures for the above listed child(ren) as may be appropriate in (a) **the signed parental dental treatment plan, (b) approving alternation in the signed parental dental treatment** for the child should parent's cannot be contacted via phone or email, and **(c) emergency circumstances** including treatment by physicians, dentists, hospital and clinical personnel and other appropriate healthcare providers.
-obtain routine medical/dental treatment from healthcare providers if symptoms of illness occur (e.g. fever, coughing, irregular breathing, unusual rashes, swallowing problems etc.)

This grant of temporary authority shall begin on _____(date) and remain effective until _____ (*leave blank if date unknown or indefinite*) or until terminated by the undersigned.

In case of emergency, the healthcare provider, should first try to contact the parent(s). If parent(s) cannot be reached, the healthcare provider should then contact the following person(s) in the order listed below:

Name: _____ Relationship: _____ Phone No: _____

Place of Employment: _____ Preferred Phone No._____ Alt. No_____

If child(ren) become ill, the healthcare provider will first try to contact the parent(s). If parent(s) cannot be reached the care provider should contact the following physician:

Physician's Name: _____ Address: _____

Physician's Phone No. _____

If the child(ren) need hospitalization the preferred hospital is _____

Hospital Address: _____

The healthcare provider may provide the physician and other healthcare providers with the following health insurance information:

Insurance Company: _____ Policy No.: _____ Policy Holder: _____

Parent's Signature: _____ Date: _____ Phone No.: _____

Parent's Signature: _____ Date: _____ Phone No: _____

INSTRUCTIONS: 1. Attach copy of Parents Driver's License 2. Print, Sign and facsimile (407-770-0171) or email (info@pediatricdentalcareorlando.com) or mail (11309 Lake Underhill Rd, Suite 103, Orlando FL 32825)