128 Mott St Suite 403, New York, NY 10013 (212)965-8113

PROXY

I, ____ (Parent or Legal Guardian) hereby, authorize (Assignee/must be over 18 years) :

1. __________________________, relationship: _________________
2. __________________________, relationship: _________________
3. __________________________, relationship: _________________
4. __________________________, relationship: _________________

to bring my child(ren) ______________________________ to Urban Pediatric Dental PC for his/her dental appointment(s). and give my authorization to the above assignee(s) to make decisions/consent to my child(ren)'s dental treatment. If you have any questions, you may contact me at the following phone number:

____

____

Signature of Parent or Legal Guardian

__________________________ __________________________

Relationship to Patient Date