**Carl D. Bloom, DMD, PA**
9641 Hillcroft Ave.
Houston, TX 77096
713-721-2275

# Dental/Medical Decision Authorization Form

Patient Name: ___________________________________ Date of Birth: ___________

Chart #: _________________

I, _______________________________, authorize_____________________________,
Name of Patient's Parent/Legal Guardian Name of Person accompanying Patient

to make any and or all dental/medical decisions on my behalf, on the date of

_______________ through the date of ________________, while accompanying

the above-named patient undergoing dental treatment with Dr. Carl Bloom.

**I have read and I understand the above information. My signature below shows that I assume full responsibility for any conditions relating to the above-named patient's dental/medical health that might be the result of the above authorization, due to the above-named individual's decision/s.**

_____________________________________________________________________
Signature of Patient's Parent/Legal Guardian Date

I, personally, reviewed the above information with the patient's parent of legal guardian.

_____________________________________________________________________
Signature of Dentist Date