Pediatric Dentistry & Orthodontics of Chattanooga

PDOC

LIMITED POWER OF ATTORNEY FOR TREATMENT OF A MINOR CHILD

1. **Power of Attorney for Health Care.** _____ (Parent or Legal Guardian), the undersigned do hereby make, constitute, and appoint_____ (name of person to give consent to treatment) as my true and lawful attorneys-in-fact, having the power to act individually, for any and all dental treatment for my minor child, _____ (minor child name) Date of Birth:_____, for me and in my name, place, and stead for Pediatric Dentistry Chattanooga, PLLC, to do each of the following things: make dental treatment decisions for my child named herein, including but not limited to the power to consent to, or refuse to consent to any care, treatment, service, or procedure to maintain, diagnose or treat any dental care, treatment or procedure, it being my intention to grant unto my attorney-in-fact all authority necessary to act for me in my stead in regard to all matters pertaining to the dental care and treatment of my child.

2. **Ratification.** I hereby ratify and confirm each act done or caused to be done by my attorney-in-fact in and about the premises by virtue of this power of attorney.

3. **Effect Date and Revocation.** This Limited Power of Attorney shall become effective upon the execution and shall remain in effect until revoked in writing by me and delivered to Pediatric Dentistry of Chattanooga, PLLC.

This ____ day of _____ _____

(Parent or Legal Guardian)

STATE OF _____: COUNTY OF _____ :

On this the ___ day of _____, 20___, before the undersigned Notary Public, personally appeared the above named person, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose names are subscribed to this instrument, and acknowledged that he/she executed it as his or her free act and deed.

My Commission Expires: _____ _____

NOTARY PUBLIC