

**PA ORAL, FACIAL & IMPLANT SURGERY LLC**  
**90 BEAVER DRIVE SUITE 101A**  
**DUBOIS, PA 15801**  
**PHONE: 814-375-0500 FAX: 814-375-0124**

Jeffrey W. Rice, D.M.D Firas Alcheikh Ali, D.M.D

**Authorization For Evaluation And/Or Treatment of A Patient Unaccompanied By  
 POA or Legal Guardian**

A POA / legal guardian must accompany a patient to consent for all medical and/or surgical treatment provided by PA Oral, Facial & Implant Surgery, LLC. Please complete this form if your patient will be coming for a visit, treatment, or procedure without a POA or legal guardian. This consent is valid for specified time period with a maximum of one year from date signed.

Patient:	Name	
	Address	
	City	
	State	Zip
	Date of Birth	Phone
Authorization for other individual to accompany patient	I authorize _____ (Name of person being authorized) Relationship to Patient	
	To give consent to medical treatment by PA Oral, Facial & Implant Surgery, LLC on behalf of my patient listed above. The above-named individual may also receive test results, additional information pertinent to the care and treatment of this patient and update medical/dental forms needed for care.	
	<u>I understand that I am still financially responsible for all medical/dental expenses incurred during these appointments.</u>	
	POA/Legal Guardian	Date Signed
	Phone number (in case of emergency)	

**\*\*THIS CONSENT IS VALID FOR ONE YEAR FROM SIGN DATE\*\***