Consent to Treat Patient Without Parent or Guardian Present

AUTHORIZATION

I have the legal right to preauthorize Signature Dental Experience and its personnel to deliver routine dental treatment and services to my child. Routine dental care may include, but not limited to: exam, teeth cleaning, fluoride treatment, x-rays, sealants, fillings and any other treatment plan previously discussed and agreed upon by the parents/legal guardians.

I, ____(print parent/legal guardian name) request and authorize Signature Dental Experience and its personnel to deliver routine dental treatment and services to my child listed below as may be deemed necessary or advisable in the diagnosis and treatment of the minor child:

Child's Name:____ DOB:_______________
Allergies:____
Current Medications:____
Chronic Conditions:____

LIMITATIONS

Indentify any specific limitations on the kinds of dental services/treatment for which this authorization is given. If none, state "NONE."__________________________________
____

PARENTAL CONTACT INFORMATION FOR ANY QUESTIONS

Parent/Guardian Name:____
Phone numbers (c)_________________(h)________________(w)__________________

I hereby authorize _____________________________________ to bring my child to his/her dental appointments if I am unable to attend. I understand that medical/dental advice will be relayed to them on my behalf. I understand and agree that the signatures and dates on this form will not expire without written notice or when the minor child turns the age of 18 and that a photocopy of this form is considered valid as the original. I also agree to accept financial responsibility for all care and services delivered prusant with this authorization.

Parent/Legal Guardian Name:_______________________________Relationship:_______

Parent/Legal Guardian Signature:_________________________________Date:________

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