Consent to Treat Patient without Parent/Legal Guardian Present

AUTHORIZATION

I have the legal right to preauthorize *Pediatric Dental Care* and its personnel to deliver routine dental treatment and services to my child. Routine dental care may include, but is not limited to: dental examinations, prophylaxis (cleaning), fluoride treatment, x-rays and any other treatment previously discussed and agreed upon by the parents/legal guardian.

I _____ (print parent/legal guardian name) request and authorize *Pediatric Dental Care* and its personnel to deliver routine dental care to my child listed below as many be deemed necessary in the diagnosis and treatment of the minor child:

Child's Name: _____ DOB: _____
Allergies: _____

Current Medications: _____

LIMITATIONS

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

PARENTAL CONTACT INFORMATION FOR ANY QUESTIONS

Parent's name_____
Contact phone: (c)_____ (h)_____ (w)_____

I hereby authorize _____ to bring my child to his/her 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 a minor becomes the age of 18 and that a photocopy of this form is considered valid as the original.

Parent/Legal Guardian name (print) _____
Relationship: _____ Parent/Legal Guardian
Signature:_____ Date: _____