CONSENT FOR DENTAL TREATMENT OF MINORS IN ABSENCE OF PARENT/LEGAL GUARDIAN

(Please fill out one form per child)

This message is a reminder for parents or legal guardians to inform the dental health provider of any medical changes regarding your child. If there are no medical changes, please check the box next to the child's name and initial to indicate the information remains the same.

Patient's Name: _____

Date of Birth ___/___/___

This consent serves as permission for treatment by Parkview Pediatric Dentistry for the above-named child. The individual bringing my child to the appointment is: _____

This statement is a parent's or legal guardian's authorization for all necessary dental treatments for their child, even in their absence. It includes routine procedures (x-rays, exams, cleaning, preventative treatments like sealants) and emergency treatments (such as extractions). By signing, the parent or guardian also agrees to cover the costs of these services.

This authorization shall remain effective:

☐ One (1) year from date signed below

OR

☐ Until ___/___/___ (Month, Day, Year)

This statement indicates that the authorization for dental treatment will remain valid until the specified date unless the parent or legal guardian evokes in writing and submits their evocation to Parkview Pediatric Dentistry before the stated date.

Parent/Legal Guardian Name

Signature

Phone Number (___)___-_____ Date: ___/___/___

Please return prior to your child's appointment.

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