Parent/ Legal Guardian Consent for Dental Treatment

Our team realizes that the parent(s) or legal guardian(s) may not always be available to attend each dental visit with the child(ren). For your convenience, please indicate below if a caregiver, grandparent, sibling or other individual is authorized to accompany your child to their visit and authorize the dental-medical care needed that day. Also, indicate if a driving age child may bring his or herself to their dental appointments.

The below named caregiver(s) shall be authorized to consent for all dental treatment, for named child(ren), which may be required during my absence. I agree to pay for all services provided to my child(ren) that are authorized by the listed caregiver(s). This authorization will remain in effect until ____________________(date), unless I revoke this authorization in writing and submit it to Dental Town prior to treatment date.

Authorized Caregiver's Information

Caregiver's Name	Relation to Patient	Phone Number

OR

❑ (Check if applies) I hereby authorize Dental Town to exam and treat my minor child(ren) **when he/she is unaccompanied by an adult**. This includes children of driving age and their siblings. I understand that I may revoke this consent at any time.

If the circumstances permit and/or Dental Town needs to contact me, please contact me at the following telephone number: ________________________

I, being the parent or legal guardian of ______________________________ authorize, request and permit the doctor and any employees under his supervision to perform any and all manner of Dental-Medical treatment that may be indicated in connection with my child, and to do whatever procedures that the judgement of the doctor may indicate during treatment. I further authorize the admission of such medication/s, anesthetic/s, and the taking of x-rays as may be deemed advisable by the doctor.

The risks and nature of treatment have and shall continue to be explained to me as treatment progresses and no warranty or guarantee has been made as to the result or cure. I assume responsibility for any and all charges incurred on behalf of my child for the Dental-Medical treatment.

Signed ___________________________ Relationship __________________________ Date ______________

Witness __________________________ Date________________