Consent to Treat Patient without Parent/Legal Guardian Present

I _____ (print parent/legal guardian name), having the legal right to do so, request and authorize *Taconic Dental* and its personnel to deliver routine dental care to my child listed below on _____ (appointment date), as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. Routine dental care may include, but is not limited to: dental examinations, prophylaxis (cleaning), fluoride treatment, x-rays, and sealants.

Child's Name: _____ DOB: _____

Allergies: _____

Current Medications: _____

Medical Conditions: _____

LIMITATIONS

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

_____

FINANCIAL

I understand that payment is due at the time services are rendered. Financial arrangements must be made prior to my child's scheduled appointment.

PARENTAL CONTACT INFORMATION FOR ANY QUESTIONS

My child will be accompanied by:

[ ] himself/ herself

[ ] other (name, relationship) _____

By signing below I also acknowledge my permission for Taconic Dental to share any relevant health information with the person who is accompanying my child.

Best Contact Number During Child's Appointment: _____

Parent/Legal Guardian Name (print):_____

Relationship to Patient _____

Parent/Legal Guardian Signature: _____

Date: _____