Authorizations for Patients 17 and Under Without a Parent or Guardian Present

Patient's Name: _____ Date of Birth: _____

If your child is 17 or under and you are anticipating that they may come in for a cleaning or operative appointment without a legal parent/guardian present or with a family member or personal representative, please fill out this form so we can see them for their appointment. **Otherwise, we will have to reschedule your child's appointment.**

(Please initial all sections)

_____ I understand that I may terminate this authorization form. I must notify this office in writing regarding termination and effective date.

_____ I understand that the dentist and such licensed dental assistants and registered dental hygienists will use restorative, oral surgery, and patient management techniques that are reasonable, necessary, and advisable.

_____ I authorize the administration of anesthetics (or analgesics) and fluoride treatments, which may be deemed advisable by the dentist.

_____ I agree to diagnostic procedures and dental treatments, which includes dental x-rays, as deemed necessary and desirable for the above named patient.

_____ I understand that the treatment plan being presented, along with the fees outlined, could change depending on the length of time since diagnosis.

_____ **I understand that I am responsible for services rendered and that all copays/fees are due on or before the day of service. Payments made by credit card must be made in person by the card holder and cannot be made over the phone for minor patients.**

Family Member or Personal Representative

_____ I authorize the following named person(s) to authorize treatment for my child by this facility:

Representative: _____ Relationship: _____

Representative: _____ Relationship: _____

Representative: _____ Relationship: _____

Signature of PARENT or GUARDIAN: _____ Date: _____

Name of PARENT or GUARDIAN: _____ Relationship to Child: _____