Patient Information for a Minor Patient

Today's date: _____

Patient name (first, MI, last)**:** _____

Patient's nickname: _____

Patient's primary residency: ☐ Both parents ☐ Mother ☐ Father ☐ Stepparent ☐ Shared custody ☐ Guardian

Address (street, city, state, ZIP)**:** _____

Home phone: _____ **Gender:** ☐ Male ☐ Female

Date of birth: _____ **Age:** _____

School: _____ **Hobbies/sports:** _____

Names and ages of other children in your family: _____

Parent / Guardian Information

Name of responsible party (first, MI, last)**:** _____

Date of birth: _____ **Relationship to patient:** _____

Address (if different from patient)**,** (street, city, state, ZIP)**:** _____

Home phone: _____ **Work phone:** _____

Mobile phone: _____ **E-mail:** _____

By providing your e-mail address you agree to receive (check one or both)**:** ☐ Appointment reminders ☐ Practice newsletter

Employer: _____ **Occupation:** _____ **Work phone:** _____

Work address (street, city, state, ZIP)**:** _____

Name of financially responsible party, (if different from above)**,** (first, MI, last)**:** _____

Is financially responsible party the same as legal guardian? ☐ Yes ☐ No

Date of birth: _____ **Relationship to patient** (mother, father or other)**:** _____

Address (if different from patient)**,** (street, city, state, ZIP)**:** _____

Employer: _____ **Occupation:** _____ **Work phone:** _____

Work address (street, city, state, ZIP)**:** _____

Dental Benefit Plan Information

Primary dental plan name: _____

Address (street, city, state, ZIP)**:** _____

Name of insured: _____ **Date of birth:** _____

ID number: _____ **Policy number:** _____

Patient relationship to insured: _____

Secondary dental plan name: _____

Address (street, city, state, ZIP)**:** _____

Name of insured: _____ **Date of birth:** _____

ID number: _____ **Policy number:** _____

Patient relationship to insured: _____

Medical Plan Information

Plan name: _____

Address (street, city, state, ZIP)**:** _____

Name of insured: _____ **Date of birth:** _____

ID number: _____ **Policy number:** _____

Patient relationship to insured: _____

Authorizations for Responsible Party Form

We are committed to providing you and your child with the best possible care. Toward this goal, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment:

cash, check, money order, credit card, 3rd party financing

Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help the parents and guardians of our patients with dental benefit plans to understand and maximize their coverage.

~~Our practice IS / IS NOT (circle one) a contracted provider with your dental benefit plan.~~ If you have HMO plans, please make sure you are assigned to our office. We accept most of PPO plans. Please verify it with our staff.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this and you will be responsible for the difference.

If we are not a contracted provider with your dental benefit plan, it is the insured's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $25.00 or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, ~~a fee of $_____~~ or deposit to reserve the appointment time again, may be required.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that my child may need and have consented to during diagnosis and treatment. (initial) _____

I have read the above and agree to the financial and scheduling terms. (initial) _____

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (Circle One) (initial) _____

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. (initial) _____

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. (initial) _____

Signature of responsible party:_____ Date: _____

Confidential Medical & Dental History for a Minor Patient

Today's Date: _____

Patient Name (first, MI, last)**:** _____ Date of birth: _____

Medical History *(Please circle Yes or No for each)*

1. Physician's name: _____ Physician's phone: _____

2. Date of last medical examination? _____ Weight: _____

3. Patient is in good health? Yes / No **If no, why?** _____

4. Patient has regular medical exams? Yes / No

5. Patient is under the care of a physician at this time? Yes / No **If yes, why?** _____

6. Patient is up to date with immunizations? Yes / No

7. Patient is presently taking medications? Yes / No **If yes, what and why?** _____

8. Patient has allergies (medications, food, latex/rubber)**?** Yes / No **If yes, what?** _____

9. Patient has been hospitalized? Yes / No **If yes, why and when?** _____

10. Patient has had any operations? Yes / No **If yes, why and when?** _____

11. Patient has had general anesthesia? Yes / No

12. If yes, were there any complications? Yes / No **If yes, please explain complications:** _____

Has the patient experienced, have or had any of the following? *(Please circle Yes or No for each)*

Yes / No	Anemia	Yes / No	Heart defects
Yes / No	Arthritis, rheumatism	Yes / No	Heart disease /defects / murmurs
Yes / No	Artificial prosthesis, organs, joints, implants, shunts, valves	Yes / No	Hepatitis
Yes / No	Asthma	Yes / No	High blood pressure
Yes / No	Blood disorder	Yes / No	Jaundice
Yes / No	Blurred vision	Yes / No	Joint pain or stiffness
Yes / No	Bone pain	Yes / No	Kidney or bladder disease
Yes / No	Canker or cold sores	Yes / No	Muscle pain, weakness
Yes / No	Chest pain, tightness, wheezing	Yes / No	Persistent cough or runny nose
Yes / No	Diabetes	Yes / No	Recent significant weight loss
Yes / No	Diarrhea or constipation	Yes / No	Rheumatic fever
Yes / No	Ear infections	Yes / No	Seizures
Yes / No	Eating disorders	Yes / No	Sexual transmitted disease
Yes / No	Excessive thirst	Yes / No	Shortness of breath
Yes / No	Eye disease	Yes / No	Skin disease
Yes / No	Fainting spells	Yes / No	Spina bifida
Yes / No	Family history of diabetes	Yes / No	Stomach problems or ulcers
Yes / No	Fever	Yes / No	Stroke
Yes / No	Frequent urination	Yes / No	Thyroid disease
Yes / No	Frequent vomiting	Yes / No	Transplants
Yes / No	Headaches	Yes / No	Tuberculosis
Yes / No	Hearing problems, ear pain	Yes / No	Tumors or cancer
Yes / No	Heart attack	Yes / No	Urinary tract Infections

This information will not be released unless specifically authorized by patient.

Yes / No	Treatment for emotional, mental, or physical delays	Yes / No	Anxiety
Yes / No	AIDS/HIV	Yes / No	Depression

13. Does the patient have or has he/she had any other diseases or medical problems NOT listed on this form? Yes / No

14. If yes, explain: _____

15. Is there any issue or condition that you would like to discuss with the dentist in private? Yes / No

(dental history continued on next page)

Dental Health History

16. Is this the patient's first dental visit? Yes / No **Please list the reason for the visit:** _____

17. Date of last dental examination: _____

18. Name of patient's previous dentist: _____

19. Reason(s) for leaving the patient's previous dentist: _____

20. Date of last dental radiographs (X-rays): _____

21. Does the patient respond well to his/her pediatrician or past dentist: Yes / No **If no, please explain:** _____

Has the patient experienced, have or had any of the following? *(Please circle Yes or No for each)*

Yes / No	Injuries to the face, mouth, or teeth	Yes / No	Habits (cheek biting, lip biting/sucking, tongue thrusting)?
Yes / No	Thumb, finger, or pacifier sucking? Until what age:	Yes / No	Speech Problems?
Yes / No	Missing or extra permanent teeth?	Yes / No	Habit of going to bed with a bottle?
Yes / No	Mouth breathing, snoring, enlarged adenoids or tonsils?	Yes / No	Jaw pain, clenching or grinding of teeth?

22. Do you live in a community with fluoridated water? Yes / No ☐ Do not know

23. Does the patient drink tap water? Yes / No

24. Does the patient use any fluoride supplements (rinses, vitamins)? Yes / No **If yes, name of product:** _____

25. How often does the patient brush his/her teeth? _____

26. Does the patient floss his/her teeth? Yes / No **If yes, how often?** _____

27. Has the patient ever been evaluated for or had orthodontic treatment? Yes / No

28. If considering orthodontic treatment, what would you most like it to accomplish for the patient? _____

Authorizations

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact the patient's physician:

Responsible Party's Signature: _____ Date: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my child's dentist of any change in my child's health and/or medication. Further, I will not hold my child's dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Responsible Party Signature (Parent or Guardian): _____ Date: _____

Signature of Dentist: _____ Date: _____

I have reviewed my child's Health History and confirm that it accurately states past and present conditions.

Parent/Guardian Signature: _____ Date: _____

Medical Updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials

COLLEGE STREET FAMILY DENTAL GROUP

Informed Consent
General Dentistry

Chart #

Name: _____

All patients complete 1 thru 4 below, and 5 thru 13 as needed. Please initial & sign highlighted sections prior to examination.

1. EXAMINATIONS AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan.

(Initials _____)

2. DRUGS, MEDICATION AND SEDATION

I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for al least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills).

(Initials _____)

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

(Initials _____)

4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)

I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

(Initials _____)

5. FILLINGS

I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling.

(Initials _____)

6. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crown, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, exposed sinuses, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

(Initials _____)

7. CROWNS, BRIDGES, VENEERS AND BONDING

a. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation.

(Initials _____)

b. I am electing to follow the Dentist's recommendation of using high noble instead of base metal in my crown and bridge restorations.

(Initials _____)

c. I am electing to do a fixed bridge or implant replacement of missing teeth instead of a removable appliance. I understand that this fixed bridge or implant and crown may not be a covered benefit under my insurance policy.

(Initials _____)

8. DENTURES – COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

(Initials _____)

9. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, and that occasionally, canal material may extend through the root tip which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reasons root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

(Initials _____)

10. PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restorative work.

(Initials _____)

11. BLEACHING

Bleaching is a procedure done either in office (approximately 1 hour) or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which will subside when treatment is discontinued. The Dentist may prescribe fluoride treatments for rare cases of persistent sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

(Initials _____)

12. NITROUS OXIDE

I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand the possible side effects that may occur. These include, but are not limited to, nausea, vomiting, dizziness and headache. I understand that nitrous oxide use is not indicated if I am pregnant.

(Initials _____)

13. DENTAL BENEFITS

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the Dentist's recommendation of optimal dental treatment.

(Initials _____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist or corporate entity, other than the treating Dentist, is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Signature: _____

Date: _____

Doctor: _____

Date: _____

DENTAL SERVICES AGREEMENT

CHART #_____

_____ ("Doctor"), and the undersigned patient ("Patient") have agreed as follows:

ARTICLE 1. IT IS UNDERSTOOD THAT ANY DISPUTE AS TO DENTAL MALPRACTICE, THAT IS AS TO WHETHER ANY DENTAL SERVICES RENDERED UNDER THIS CONTRACT WERE UNNECESSARY OR UNAUTHORIZED WERE IMPROPERLY, NEGLIGENTLY OR INCOMPLETELY RENDERED, WILL BE DETERMINED BY SUBMISSION TO ARBITRATION AS PROVIDED BY CALIFORNIA LAW, AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OR ARBITRATION PROCEEDINGS, BOTH PARTIES TO THIS CONTRACT BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF ARBITRATION.

ARTICLE 2. In the event of any claim, demand, controversy or dispute the essential nature of which involves personal injury, malpractice or any tort, by Patient, his dependents, whether or not minors, heirs at law or personal representatives against Doctor or any of Doctor's officers, directors, shareholders, agents, representatives, employees, successors in interests, assigns or associates agreeing in writing to be bound by the arbitration provisions of this agreement (Affiliates"). THE SOLE METHOD FOR RESOLVING SUCH DISPUTE SHALL BE BINDING ARBITRATION ADMINISTERED BY THE AMERICAN ARBITRATION ASSOCIATION in accordance with Commercial Arbitration Rules of the American Arbitration Association. The parties hereby agree that they shall submit their controversy to an Arbitrator, who is a Dentist licensed in California. Such Arbitrator shall be acceptable to both parties. In the event that the parties cannot agree upon a sole Arbitrator, each party shall pick an Arbitrator who is a licensed Dentist in California and the two Arbitrators shall pick a third Dentist proceeding under the rules of the American Arbitration Association. Not withstanding the foregoing, two additional Arbitrators who are Dentists may be added by the parties by agreement in writing to create an arbitration panel of three. It is agreed that all parties relevant to a full and complete settlement of any dispute subject to this agreement may be intervened or joined.

ARTICLE 3. The prevailing party in any arbitration pursuant to this agreement shall be awarded all costs, including reasonable attorneys' fees and the Arbitrators' fees, in prosecuting or defending that claim in arbitration, but not to exceed $5,000 in amount. Furthermore, if any action is undertaken to set aside or otherwise attack the binding arbitration award, the losing party in the court action shall bear all the prevailing party's costs, including reasonable attorneys' fees.

ARTICLE 4. Any party initiating arbitration under this agreement shall file with his petition a bond or cash surety in an amount equal to Five Hundred Dollars ($500) which shall provide security for attorneys' fees and costs in the event that the moving party shall not prevail.

ARTICLE 5. This agreement shall govern all future services rendered to Patient by Doctor and Doctor's Affiliates and Associates. Execution of this agreement is a precondition to the furnishing of services by Doctor, but this agreement may be rescinded by written notice by either party within thirty days of signature. After those thirty days, this agreement may be changed or revoked only by a written revocation signed by both parties.

ARTICLE 6. I understand that each Doctor is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Doctor or corporate entity, other than the treating Doctor, is responsible for my treatment.

ARTICLE 7. Doctor hereby agrees to render dental care and service to Patient. Patient agrees to pay Doctor promptly upon rendering of a bill at the current prevailing rates, or to cooperate with Doctor in obtaining payment from third party payors.

ARTICLE 8. Except for the fact that Doctor has indicated professional services will not be rendered to Patient unless this agreement is executed, Doctor has made no other representations or statements, oral or written, to induce Patient to execute this agreement.

ARTICLE 9. In the event that any provision of this agreement shall be void or unenforceable for any reason whatsoever, then such provision shall be stricken and of no force and effect. The remaining provisions of this agreement, however, shall continue in full force and effect, and to the extent required, shall be modified to preserve their validity. This agreement shall be governed by California law.

THIS IS A BINDING LEGAL DOCUMENT WHICH MAY HAVE AN IMPORTANT EFFECT OF YOUR LEGAL RIGHTS. CONSULT YOUR ATTORNEY ON ANY QUESTIONS YOU MAY HAVE.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____
(PATIENT'S SIGNATURE)

_____
(PATIENT'S AGENT OR REPRESENTATIVE)

_____
(RELATIONSHIP TO PATIENT)

_____
(DOCTOR)

DATE OF SIGNING _____

_____ **AM/PM**

Authorization for a Care-Taker
(non-legal guardian) to Accompany a Minor to Appointments

Patient Name (first, MI, last)**:** _____

Patient Social Security Number: _____

I _____ (legal guardian name) authorize _____ (name of care-taker) to bring my minor child _____ (child's name) to College Street Family Dental Group (practice name) for scheduled appointments for treatment in which a legal guardian to my child has previously consented be performed on my child.

I understand this authorization for a care-taker to accompany my minor child to appointments does not permit the care-taker to consent to treatment on behalf of a legal guardian. I understand that only a legal guardian may consent to treatment for my child.

If treatment consent, that has not been previously diagnosed and accepted by a legal guardian authorized as such with this practice, is required at an appointment in which a care-taker is accompanying my minor child, the legal guardian will be contacted prior to proceeding with the treatment plan. If the legal guardian cannot be reached to provide treatment consent, the treatment will not be performed.

I understand that only a legal guardian may accompany my minor child to an appointment in which sedatives are scheduled to be administered, regardless of whether the sedation technique was previously consented to by a legal guardian authorized as such with this practice.

I understand that this authorization will remain in effect until the practice is otherwise notified of the above designated care-taker's change in status. I understand that it is my responsibility, as the legal guardian, to inform this practice of any change to this authorization.

Parent / Legal Guardian Signature: _____ Date: _____