Santa Rosa Pediatric Dentistry

Authorization – Dental Care of a Minor When a Parent is not Present

Patient: ______________________________ Birthdate: ______________________

Person(s) I authorize to accompany my child:

Name: ______________________________ Relationship to Child: __________________

Name: ______________________________ Relationship to Child: __________________

I ____________________________ authorize my caretaker to bring my minor child to Santa Rosa Pediatric Dentistry to provide treatment to my child that I have previously consented to. I understand this form does not permit the caretaker 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 caretaker 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.

This authorization will remain effective unless terminated by written notice.

Phone number where parent can be contacted during treatment, if needed:

Home: __________________ Work: __________________ Cell: __________________

Signature of parent or legal guardian: ______________________________________

Date: ______________________ Relationship to Patient: ________________________