Kids Dental Care

AUTHORIZATION FOR THIRD PARTY TO CONSENT TO

TREATMENT OF A MINOR

I am the __ Parent ___Guardian ___ other person having legal custody _____

(*Must provide photo ID*) (*Describe legal relationship*)

Of (name of minor) _____, a minor.

I hereby authorize (_____) X-Ray examination, anesthetic, dental diagnosis, or treatment of the licensed dentist.

I hereby authorize (_____) to sign all informed consents and any and/ or required treatment plans pertaining to the child's visit.

I understand that this authorization is giving in advance of any specific diagnosis, treatment being required, but is given to provide authority to the above-named agent to give consent to any and all such diagnosis, treatment which a licensed dentist recommends.

These authorizations shall remain effective until (*month and day*) _____20____, unless sooner revoked in writing delivered to the agent named above.

Date: _____ Time: _____ AM/PM

Signature: _____

(*Circle relationship: parent/legal representative/person having legal custody*)

Print Name: _____

(*Circle relationship: parent/legal representative/person having legal custody*)

Witness: _____

MEDICALLY RELEVANT INFORMATION (REQUIRED)

Minor's Name: _____

Minor's date of birth: _____

Allergies to drugs or food: _____

Condition for which minor is currently being treated: _____

_____

Current medications: _____

_____

Restrictions on activity: _____

Primary care physician (*name and telephone number*)