Consent to Treat Minor Without Parent/Legal Guardian Present

DENTAL COLLABORATIVE
DR. HARRY P. TREON
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Patient's Full Name: _____ Date of Birth: _____

To allow for treatment of patients who are considered minors, it is necessary for a parent or legal guardian to give consent for treatment. In the event that a minor child presents for a non-urgent appointment without a parent or legal guardian or a signed consent, treatment may be denied.

To Consent To:

_____ Emergency or urgent care when I cannot be reached.

_____ Routine dental care, which may include, but not limited to: dental examinations, prophylaxis (cleaning), fluoride treatment, xrays and any and all other treatment previously discussed and agreed upon by the parents/legal guardian.

The individual bringing my child to the appointment is named, _____ and is at least eighteen years of age and is the patient's _____.

_____ I also give this Individual permission to make decisions regarding my child's dental treatment, and medical treatment (if necessary should an emergency arise). I understand payment is expected at the time of treatment.

I can be reached at the following number if there are any questions: _____

I/We _____ (printed parent/guardian name) authorize Dental Collaborative to provide treatment. My authorization is effective until Minor Child reaches age 18, or until I revoke my authorization in writing.

_____ _____ _____

Signature of Parent/Guardian **Relationship to Patient** **Date**