

## Consent to Treat Patient Without Parent/Legal Guardian Present

### AUTHORIZATION

I have the legal right to preauthorize *Rising Stars Pediatric Dentistry* and its personnel to deliver routine dental treatment and services to my child. Routine dental care may include, but is not limited to: dental examinations, prophylaxis (cleaning), fluoride treatment, x-rays and any other treatment plan previously discussed and agreed upon by the parents/legal guardian.

I \_\_\_\_\_ (print parent/legal guardian name) request and authorize *Rising Stars Pediatric Dentistry* and its personnel to deliver routine dental care to my child listed below as may be deemed necessary or advisable in the diagnosis and treatment of the minor child:

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Chronic Conditions: \_\_\_\_\_

### LIMITATIONS

Identify any specific limitations on the kinds of dental services/treatment for which this authorization is given. If none, please state "NONE".

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### PARENTAL CONTACT INFORMATION FOR ANY QUESTIONS

Parent's name \_\_\_\_\_

Contact phone: (c) \_\_\_\_\_ (h) \_\_\_\_\_ (w) \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to bring my child to his/her appointments if I am unable to attend. I understand that medical/dental advice will be relayed to them on my behalf. I understand and agree that the signatures and dates on this form will not expire without written notice or when a minor becomes the age of 18 and that a photocopy of this form is considered valid as the original.

Parent/Legal Guardian name (print) \_\_\_\_\_ Relationship: \_\_\_\_\_

Parent/Legal Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_