



Rising Stars Pediatric Dentistry

CONSENT TO TREAT

CONSENT TO TREAT WITHOUT PARENT/LEGAL GUARDIAN PRESENT

I _____ (print parent/legal guardian name) have the legal right to preauthorize Rising Stars Pediatric Dentistry and its personnel to deliver routine dental treatment and services to the patients listed below and I request and authorize Rising Stars Pediatric Dentistry and its personnel to deliver routine dental care to said patient(s). Routine dental care may include, but is not limited to, dental examinations, prophylaxis (cleaning), fluoride treatment, x-rays, and any other treatment deemed necessary or advisable in the diagnosis and treatment of previously discussed and agreed upon treatment plan(s) with the parents/legal guardians.

PATIENT(S) INFORMATION

FIRST NAME _____ MIDDLE _____ LAST NAME _____ BIRTH DATE __ / ____ / ____
FIRST NAME _____ MIDDLE _____ LAST NAME _____ BIRTH DATE __ / ____ / ____
FIRST NAME _____ MIDDLE _____ LAST NAME _____ BIRTH DATE __ / ____ / ____
FIRST NAME _____ MIDDLE _____ LAST NAME _____ BIRTH DATE __ / ____ / ____

LIMITATIONS

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

PARENT/GUARDIAN INFORMATION

FIRST NAME _____ MIDDLE NAME _____ LAST NAME _____ PREFERRED _____
RELATION TO PATIENT Father Stepfather Mother Stepmother Guardian Other _____
WORK # _____ CELL # _____ HOME # _____

I hereby authorize _____ to bring the patients listed above to their 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.

Signature of Parent or Guardian _____ Date _____

Printed Name _____