



Consent to Treat Minor-Without Parent/Legal Guardian Present

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives without the parent or legal guardian or with someone other than a parent or legal guardian, there must be written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minor's Name: _____ **DOB:** _____

Parent(s) or Legal Guardian(s): _____

For those occasions when you may not be with your child, please list those individuals who may give us consent to see and treat your child:

| Name | Relationship to Patient | Telephone |
|------|-------------------------|-----------|
|------|-------------------------|-----------|

| Name | Relationship to Patient | Telephone |
|------|-------------------------|-----------|
|------|-------------------------|-----------|

LIMITATIONS:

Identify any **specific limitations** on the kinds of dental services for which this authorization is giving. If none, then state "none".

This Shall Be in Effect For: **Date**_____ **Only**

No Expiration Date, unless revoked by written communication

AUTHORIZATION:

I, (parent/legal guardian name) _____ request and authorize Advanced Dental Associates, L.L.C and its personnel to deliver dental care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child.

I have the legal right to preauthorize Advanced Dental Associates, L.L.C. and its personnel to deliver routine dental treatment and services to my child. Routine dental care may include prophylaxis, any necessary x-rays, fluoride treatment, exams, sealants and y restorative dental treatment.

I have read, understand and give my consent as stipulated above. I have read this form and/or have had it read to me and explained in a language that I can understand.

Signature of parent/legal guardian

Date