
# Authorization to Treat Patient without Parent or Guardian Present

**Parent/ Guardian Name Filling is form:_____ Date of Appointment: _____**

I authorize the person listed below to accompany my child, _____ to his/her dental appointment.

Authorized Person's Name: _____ Authorized Person's Relation_____

I agree to the following treatment to be performed in my absence: Examination, Radiographs (x-rays) , Cleaning, Fluoride, Silver diamine fluoride, restoration of decayed teeth, Nitrous oxide (laughing gas) Extractions, and Emergency treatment as necessary.

I request that I be contacted at the phone number below: If treatment needs or recommendations change during treatment.

Phone: _____

If treatment recommendations change during treatment and I am not able to be reached I authorize the person accompanying my child to make an informed decision and authorize ABC Dentistry to perform the necessary and recommended treatment. I understand this guardian authorization will remain in effect until revoked in writing.

Parent / Guardian Name: _____

Signature: _____

Date: _____