CONSENT FOR DENTAL TREATMENT OF MINORS IN ABSENCE OF PARENT/LEGAL GUARDIAN
(Please fill out one form per child)

PLEASE NOTE that if there are any medical changes, the parent or legal guardian **MUST** speak directly with the dental health care provider. If no changes, please check box next to child's name and initial.

Patient's Name ____

Date of Birth ____

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This consent serves as permission for treatment by Grimes Pediatric Dentistry for the above-named child. The individual bringing my child to the appointment is: ____.

I give my authorization for all dental treatment including routine procedures that may be required during my absence: x-rays, exams, prophy, preventive procedures including sealants, as well as emergency dental treatment such as extractions, for the above-named child. I agree to pay for all services provided to my child.

This authorization shall remain effective:
❒ One (1) year from date signed below
OR
❒ Until ______________________________ (Month, Day, Year)

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This authorization will remain in effect until the date stated above unless I revoke this authorization in writing and submit it to Grimes Pediatric Dentistry prior to this date.

Parent/Legal Guardian Name ____

Signature ____

Phone Number ______________________________ **Date** _________________________________

Please return with child at time of appointment.