Capital District Pediatric Dentistry

where smiles grow.

Authorization for evaluation and/or treatment of a minor child unaccompanied by parent or legal guardian.

A parent or legal guardian must accompany a child younger than 18 years of age to consent for all dental treatment provided by Dentistry for Children & Adolescents. Please complete this form if your child will be coming for a visit without a parent or legal guardian.

Minor Patient(s):	Name & Date of Birth_____ Name & Date of Birth_____ Name & Date of Birth_____ Name & Date of Birth_____
Time Period:	**Written consent is valid for the time period of:** _____ **to** _____. **OR** ☐ **Indefinitely** This consent may be revoked by me at any time in writing.
Authorization for other individual to accompany minor patient <u>under</u> 18 years of age.	I authorize _____ _____ Name of person(s) being authorized Relationship to patient To give consent for dental treatment by Dentistry for Children & Adolescents on behalf of my child(ren) listed above, which may be required in my absence. <u>I understand that I am still financially responsible for any services provided to my child(ren) that were approved by authorized person(s).</u> **Parent / Legal Guardian Signature** Date Signed Phone number (in case of emergency) _____
Authorization for minor patient to be unaccompanied for visits.	I authorize and give consent for my child(ren), listed above, to go independently to appointments and consent to all dental treatment by Dentistry for Children & Adolescents without the presence of a parent or legal guardian. <u>I understand that I am still financially responsible for any dental expenses incurred by my child(ren) during these appointments.</u> **Parent / Legal Guardian Signature** Date Signed Phone number (in case of emergency) _____

Note: Consents are NOT required in emergency situations.

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Specializing in dentistry for infants, children & adolescents

Active Members of the
American Academy of Pediatric Dentistry