

Patient Name: _____

Date of Birth: _____

Practice location: _____

The Smile Center

CONSENT FOR TREATMENT OF A MINOR PATIENT

To facilitate dental care and treatment of my child, _____, (Minor Patient), by The Smile Center, the undersigned parent or legal guardian of the Minor Patient hereby agrees as follows:

- 1. Direct Authorization for Treatment by The Smile Center.** A dental examination has been completed at The Smile Center and a treatment plan has been given to me for the above named patient. All risks/benefits and alternatives to treatment have been explained to me. I have been given an opportunity to ask all questions and they have been adequately answered. I verify that I have legal authority to grant consent for the treatment of the above named patient. I authorize The Smile Center to provide the Minor Patient with the following treatment: .

Tooth cleaning	Extraction of "baby" teeth
Sealants	Extraction of permanent teeth
Fillings	Root Canal Treatment
Fluoride	Other _____

(This allows a minor patient to come to an appointment(s) unaccompanied by parent/guardian/parent substitute.)

- 2. Identification of Parent Substitute.** I appoint the following Parent Substitute(s) to obtain access to Protected Health Information or give informed consent for care and treatment.

Name	Relationship to Minor	Phone Number
_____	_____	_____

- 4. Duration.** This authorization is valid for the specific treatment plan explained and agreed to on _____ (date). This authorization will be voided if significant changes occur in the treatment plan, if patient fails appointments or if oral conditions have changed and another dental examination is required within a 6 month period of time.

I have carefully read and considered this consent form before signing it.

SIGNATURE OF PARENT OR LEGAL GUARDIAN:

Signature	Date
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<u>Legal Authority:</u>	Parent of Minor	Legal Guardian
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CONTACT INFORMATION CONCERNING PARENT OR LEGAL GUARDIAN:

Name	Relationship to Minor	Contact Phone Number
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