Shadow Creek
PEDIATRIC ▪ DENTISTRY

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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 _____

This consent serves as permission for treatment by Shadow Creek 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)

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

Parent/Legal Guardian Name _____

Signature _____

Phone Number _____ Date _____

Please return with child at time of appointment.