Authorization for Dental Care on a Minor
Informed Consent

Form content will be retained in dental record

Patient Name *(First, Middle, Last)*	Date
Office Name	Dentist Name

I am being provided with this information and consent form so that I may better understand the treatment recommended for my child. Before making a treatment decision, I wish to be provided with sufficient information, in a way I can understand, in order to make a well-informed decision regarding the proposed treatment for my child. I understand that I may ask any questions I wish and that it is better to ask questions prior to treatment than to wonder about them after treatment has started.

Acknowledgments:

I, _____, am the parent or legal guardian of _____, who is of _____ years of age. I authorize dental treatment determined by the medical professionals to be necessary, to be rendered on my child/minor, without my physical presence in the dental office.

- I have been advised that it is ideal to have a parent/legal guardian present in the office during treatment in case of any complications or medical situations that may arise.
- With knowledge of this, I authorize the _____ care team to take any emergency care/action or precautions deemed necessary.
- I acknowledge I retain the authority to approve or decline treatment to be rendered and will make that designation clear before the appointment either in person or by phone consent.

Effective Dates:

This authorization is effective from _____ to _____.

Allergies, Medications, or Other Pertinent Information of Child, if any:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Emergency Contact Information:

In case of emergency, I can reached by phone at _____.

Secondary contact if any:

Name: _____

Relationship to Patient: _____

Phone number: _____

Child/Minor Name	
Signed (Patient or Guardian)	Date
Signed: (Treating Dentist)	Date
Signed: (Witness)	