

**Parental/Legal Guardian Consent for Dental Treatment**

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| --- | --- |
| Name of Child | Date of Birth |
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I understand that it is my responsibility to inform Ascension Children’s Dental of any medical/dental changes for the above named child(ren) in writing. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (initial)

**Authorized Caregiver’s Information**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Caregiver’s Name Relationship to Child(ren) Home Phone Number Cell Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Caregiver’s Name Relationship to Child(ren) Home Phone Number Cell Phone Number

The above named caregiver(s) shall be authorized to consent for all dental treatment, for the above named child(ren), which may be required during my absence.

**Limitations for dental services/treatments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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I agree to pay for all services provided to my child(ren) that the caregiver authorized. I understand payment is expected at the time of treatment.

This authorization will remain in effect until the date stated below- unless I revoke this authorization in writing and submit it to Ascension Children’s Dental prior to this date. This consent serves as permission for treatment by Ascension Children’s Dental for the above named child(ren).

**This authorization shall be effective for one year from date signed.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_\_

**Parent/Legal Guardian Printed Name Home Number Work Number Cell Number**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Legal Guardian Signature**  **Date**