CONSENT TO PROVIDE PREVENTIVE SERVICES TO A MINOR CHILD IN THE ABSENCE OF THEIR PARENT OR LEGAL GUARDIAN

I, _____, as the parent / legal guardian, of _____ , do hereby authorize the doctors and staff of this office to provide preventive dental services to my child / dependent, in my absence.

By providing this authorization, I assume complete responsibility for notifying the Doctors and staff, <u>prior to treatment</u>, of any changes in my child's / dependent's medical history.

This authorization includes permission to provide the following services. Please check all that apply:

____ Oral Examination

____ Diagnostic X-Rays, which may include:
____ Bitewings – for cavities detection

____ Periapicals – to evaluate problems with a particular tooth

____ Cleaning

____ Fluoride Treatment

____ Sealants

I understand that all services may not be covered by my insurance plan, and that I will be responsible for payment in full of all services rendered.

This authorization will remain in force, until such time as I <u>personally</u> notify the doctor or clinical staff of any changes.

Signature: _____ Date: _____