SHORES
FAMILY DENTISTRY

Consent to Treat Patient-without Parent/Legal Guardian present

I _____hereby authorize _____

(Print name/relationship to patient) (Patient name)

to bring his/herself to appointments if I am unable to attend. I understand that dental advice will be relayed to them on my behalf and dental treatment rendered. I authorize the following dental procedures to be performed by the doctor, hygienist, & dental assistant.

_____ Dental Prophy (cleaning)

_____ Dental Examination

_____ Radiographs

_____ Fluoride

_____ Dental Restorations (including but not limited to sealants, fillings, extractions)

Patient DOB:

Allergies:

Changes to Medical History since last visit:

Parent/Guardian Phone Number:

This form expires one year from date signed or if minor patient turns 18. I understand that a new form must be completed to make updates or changes to consent.

Parent/Guardian name _____
(Please print)

Parent/Guardian Signature_____Date_____