Pediatric DENTAL SPECIALISTS, P.A.
CREATING SOMETHING TO SMILE ABOUT!

AUTHORIZATION FOR TREATMENT OF A MINOR
Please include any/all children you are authorizing consent for:

I, _____, parent(s)/legal guardian(s) of:

_____, a minor child born on ____/____/____,

_____, a minor child born on ____/____/____,

_____, a minor child born on ____/____/____,

_____, a minor child born on ____/____/____,

_____, a minor child born on ____/____/____,

_____, a minor child born on ____/____/____,

Hereby authorize other than legal parent / guardian:

_____ _____
(Name) (Relationship to child) (Name) (Relationship to child)

_____ _____
(Name) (Relationship to child) (Name) (Relationship to child)

to give consent for the dental treatment of the above named child(ren) for any dental condition that he/she may encounter; or to bring the child(ren) to PDS for routine checkups and associated procedures deemed necessary by PDS. I also authorize the dentist, hygienists, and staff at PDS to give information to the individual(s) named above regarding the diagnosis and plan of treatment, or any information necessary for the care of the above named child(ren).

- I hereby release PDS of any liability regarding release of this information on the above named child(ren).
- I understand that if someone other than the above listed on this form brings my child(ren) to the dental appointment, my appointment will be rescheduled for another time.
- I understand that only the above listed have permission to make decisions regarding my child(ren)'s dental treatment, and it is my or other legal guardian's responsibility to notify PDS of any desired changes.
- I understand changes can be made by a parent or legal guardian at anytime by filling out a new authorization for treatment of a minor, as these changes are not considered addendums to the existing form.
- I understand that even though I have authorized the above named to make treatment decisions regarding the above named child(ren), I will be financially responsible for this family account, and **I understand that payment is due at the time of service.**

_____ _____
Parent/Legal guardian Date Parent/Legal guardian Date

Please INITIAL if applicable:

_____I hereby authorize my child (age 15 with proof of hardship license, or 16 and above) to receive dental treatment (i.e. dental exams, x-rays, cleaning, fluoride, treatment with or without nitrous oxide but excluding oral sedation) without an authorized person accompanying him/her. I understand that a parent or legal guardian will be responsible for completing the medical history and all necessary paperwork prior to the appointment until my child is 18 years of age.