TREATMENT OF MINOR CHILDREN
NO PARENT/LEGAL GUARDIAN PRESENT

At Bozart Family Dentistry, we understand that from time to time you may not be able to bring your child to their dental appointment. We will treat your child without you present for some, but not all dental procedures.

AUTHORIZATION: I have the legal right to preauthorize Bozart Family Dentistry and their personnel to deliver routine dental treatment and services to my child. Routine Dental care and interventions may include, but are not limited to: dental evaluation, exam, dental x-rays, cleaning of teeth and orthodontic services.

I, ______________________________ request and authorize Bozart Family Dentistry and their personnel to deliver routine dental care to my child listed below as may be deemed necessary or advisable in the diagnosis and treatment of the minor child:

Child's Name: ________________________________ DOB: ________________
Allergies: ____
Current Medications: ____
Chronic Conditions: ____

LIMITATIONS: Identify any specific limitations on the kinds of dental services for which this authorization is given. If none, state "none"___________________________________

Parental contact information for questions regarding treatment of the child:

Parent's Name: ____
Contact Info: (Cell) _______________________ (Home) ____________________
Mailing Address: ____
City ________________ State __________ Zip Code _____________

I hereby authorize _________________________________ 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. I understand and agree that the signatures and dates on this form will not expire without written notice or in case that a minor becomes the age of 18 and that a photocopy of this form is considered valid as the original.

Parent/Guardian Signature____Date______________