We Make It Bearable

Mark W. Gardner, D.D.S., M.S.
Pediatric Dentistry

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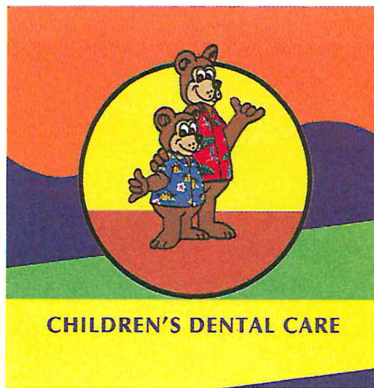
Pediatric Dentistry



www.childrensdentalcare.org

Practice limited to
dentistry for infants,
children and teens

PERMISSION TO AUTHORIZE CONSENT FOR TREATMENT

I am the parent/legal guardian of the following named child/ward ____________________, whose date of birth is ___________________. I have the legal right to consent to medical and surgical treatment for this child/ward. I hereby authorize the following individual(s), ____, whose relationship to this child/ward is __________________________, to give legal informed consent to any and all dental//surgical care, treatment and/or attention for this child/ward which is deemed necessary and appropriate by a healthcare provider licensed in the state in which the care and treatment is to be provided.

I further agree to reimburse Children's Dental Care for the cost of rendering services which are not covered by insurance or health plan. The child is covered under the following dental plan: ____

I can be reached at the following address and telephone number:

____

I understand that if any medical/dental/surgical history changes from the completed medical history form, that I will notify the office prior to any future appointments.

Authorization to consent expires: ____

(Will expire automatically after two years of signature unless otherwise indicated)

____________________________   **_________________**

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

_____________________________   **I am the: Parent ☐ Legal Guardian ☐**

Printed Name of Parent/Legal Guardian

____________________________ Office Witness

___________________Time/Date

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