Children's DENTAL CENTRE

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childrensdentalcentresc.com

CONSENT TO DISCUSS HEALTH INFORMATION

Please complete the following sections below, **if applicable.**

Please list any other parties who may have access to your child's dental information:
(This includes step parents, grandparents and any caretakers who may have access to this patient's records):

Name:_____Relationship:_____Phone #:_____

Name:_____Relationship:_____Phone #:_____

Name:_____Relationship:_____Phone #:_____

Name:_____Relationship:_____Phone #:_____

Name:_____Relationship:_____Phone #:_____

CONSENT TO DENTAL CARE FOR A MINOR
(when a parent or legal guardian cannot be present)

If you do NOT plan to accompany your child to their appointment or your child will be brought by someone other than their parent/legal guardian, please complete form below:

I cannot accompany my child, _____ to the scheduled dental appointment. I hereby give consent for my child to be evaluated and receive routine dental treatment at Children's Dental Centre.

- ☐ Another adult will accompany my child to the appointment. I hereby appoint _____ as my representative. I empower him/her to act as legal guardian during this appointment. The dental provider may reach me during the appointment at _____to discuss any significant changes to the agreed upon dental treatment plan.
- ☐ My child will not be accompanied to the appointment by an adult. The dental care provider may reach me at _____ during the appointment to discuss any significant changes to the agreed upon dental treatment plan.

I understand that a medical history will be taken and a comprehensive dental examination may be performed. Necessary procedures such as x-rays, cleanings, and dental fillings may be done if needed. I accept responsibility for all costs related to such treatment.

The following is a list of specific procedures that may ***not*** be performed unless there is expressed permission from me (via contact by telephone): _____

Patient's Name:_____DOB:_____/_____/_____

Patient's Name:_____DOB:_____/_____/_____

Patient's Name:_____DOB:_____/_____/_____

Patient's Name:_____DOB:_____/_____/_____

_____ _____
Signature of Parent/Legal Guardian Date