Lone Star Pediatric Dental

AUTHORIZATION FOR AGENT TO CONSENT TO DENTAL TREATMENT OF A MINOR

I hereby authorize _____ (an adult into whose care the minor(s) has been entrusted) to consent to an x-ray, examination, anesthetic, or dental diagnosis and treatment of _____ deemed advisable by a dentist and provided by that dentist and staff or under the dentist's supervision.

I understand that my child will be having the following treatment: ***Parent, please initial next to X***

X _____ Fillings (amalgam (silver) and/ or composite (white) fillings)

X _____ Extractions (removal of teeth)

X _____ Stainless Steel Crowns

X _____ Root Canal (nerve treatment)

X _____The use of Nitrous Oxide – If this fee ($45) is not paid by my insurance, I am financially responsible. (Payment is due on the day of the visit).

X _____The use of Sedation – If this fee ($75) is not paid by my insurance, I am financially responsible. (Payment is due on the day of the visit).

X _____ Other _____

_____

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on teeth. I give my permission to the dentist to make any/all changes. This authorization is valid until revoked by me in writing.

I have had explained to me, and I have had sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment, compared with alternative approaches and/or no treatment.

Signature: _____ Date: _____

Witness: _____

Please specify relationship to minor:

_____ Parent with legal lustody _____ Guardian with legal custody