emhardt
PEDIATRIC DENTISTRY

where smiles grow up

PROXY CONSENT TO TREAT MINORS

This form may be used to allow an adult other than a parent to serve as a proxy decision maker for routine dental care and services at Emhardt Pediatric Dentistry.

For some families, it may be convenient to have prior authorization in place that allows routine dental care to be delivered to minors under the care of a proxy decision maker if a parent or legal guardian cannot be present to provide consent. If you would like to appoint a proxy decision maker, please review and complete the following form authorizing dental treatment or services for the care of a minor child.

Appointed Proxy

1) _____ _____
NAME RELATIONSHIP

2) _____ _____
NAME RELATIONSHIP

3) _____ _____
NAME RELATIONSHIP

4) _____ _____
NAME RELATIONSHIP

As a proxy decision maker to consent to and authorize dental care for my child(ren) listed below. This proxy extends to care deemed necessary by the dentist(s) to treat the conditions present. This consent includes, but is not limited to routine preventive, restorative procedures, and use of Nitrous Oxide. I understand that treatment recommended and rendered is based on what the dentist(s) believe is in the best interest of the patient. This treatment is not based on insurance coverage, and I understand that failure of an insurer to pay for a procedure does not relieve me of the financial obligation for this treatment. (More than one child may be listed)

Child's Name_____ DOB: _____

Child's Name_____ DOB: _____

Child's Name_____ DOB: _____

Child's Name_____ DOB: _____

LIMITATIONS:

Identify any limitation on the kinds of dental services for which this authorization is given (if none, please state "none"):

_____

Parental contact information for questions regarding treatment:

Father's Name: _____ Mother's Name: _____

Cell Phone: _____ Cell Phone: _____

I hereby identify and hold harmless Emhardt Pediatric Dentistry from any and all liability for acting in reliance on this authorization. The individual appointed as proxy is permitted to make decisions or consent to the care in my absence. I agree to accept financial responsibility for all care delivered pursuant to this authorization.

_____ Date: _____
Signature of Parent or Legal Guardian

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