TREATMENT OF MINOR CHILDREN

NO PARENT/LEGAL GUARDIAN PRESENT

At Sardina Dental Group, 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 any and all dental procedures provided that:

1. The child is 16 years old or older.
2. The parent/legal guardian is available by telephone.
3. The parent/legal guardian has signed all required documentation.
4. The parent/legal guardian has informed our office that they will not be present during the appointment before the child comes into their appointment.

Minor children who are able to drive themselves to their appointments must bring written documentation from their parent/legal guardian giving permission to Sardina Dental Group to perform any and all dental procedures.

Pennsylvania State Law assumes consent to emergency treatment has been given. As such the doctor should proceed in calling local emergency services if needed. In the event that an emergency or unexpected incident occurs, it is imperative that the parent/legal guardian be reachable.

Please see the form below giving us permission to treat your child/children without a parent/legal guardian present.

PERMISSION TO TREAT (Please Print Clearly)

I, _____, give permission to Sardina Dental Group and staff to perform all dental treatment on my child_____ including, but not limited to fluoride treatments, diagnostic radiographs, examination, composite fillings, sealants and extractions. If additional treatment is needed, Sardina Dental Group has my permission to perform that treatment regardless of my presence in the office.

In the event of an emergency, Sardina Dental Group and staff have my permission to take any and all necessary steps to ensure the safety and well-being of my child.

I understand and agree to Sardina Dental Group's Treatment of Minor Consent Form and its terms.

Name of Parent/Legal Guardian (please print):_____

Signature of Parent/Legal Guardian:_____

Relationship to Patient:_____Patient Date of Birth:_____

Best Contact Telephone Number while your child is in the office:_____

Alternate Contact Number:_____ Date of Appointment_____

SARDINA DENTAL GROUP

Parental/Legal Guardian Consent for Dental Treatment

(Please fill out one form per child)

PLEASE NOTE that if there are any medical changes, the parent or legal guardian MUST speak directly with the dental health provider. If not changes, please check box next to child's name and initial.

_____ _____☐ NO medical changes

Child's Name Date of Birth _____

Please initial

_____ _____

Parental/Legal Guardian Contact (please print) **Phone Number**

This consent serves as permission for treatment by Sardina Dental Group for the above named child.

I give my authorization for all dental treatment, for the above named child, which may be required during my absence. I agree to pay for all services provided to my child.

This authorization shall be effective until:

☐ One (1) year from date signed below

OR

Until_____(list Month, Day, Year)

This authorization will remain in effect until the sate stated above unless I revoke this authorization in writing and submit it to Sardina Dental Group prior to this date.

_____

_____

Signature of Parent/Legal Guardian (circle one) Date

Please return with child at time of appointment.