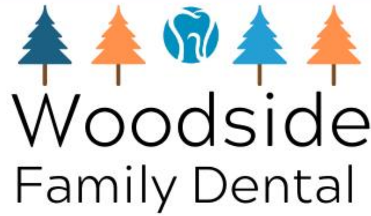

Authorization to Treat a Minor

Patient's Name: ____

I, being the parent or guardian of the above minor patient, hereby do authorize and request the performance of dental services for this patient and the use of whatever procedures Dr. Corey J. Brenner may deem necessary during treatment.

I understand that the dentist and such Licensed Dental Assistants and Registered Dental Hygienists may designate to treat the above-mentioned patient, will use restorative, oral surgery and patient management techniques that are reasonable, necessary and advisable.

I also authorize the administration of anesthetics (or analgesics) and fluoride treatments, which may be deemed advisable the dentist.

I understand that the treatment plan to be presented, along with the fees outlined, could change depending upon the time elapsed since the initial examination and the extent of dental pathology.

I agree to diagnostic procedures and dental treatments, to include the use of dental x-rays, as deemed necessary and desirable for the above-named patient.

This agreement allows the above-mentioned patient is over age 14 and may attend the dentist without my presence. This agreement expires on above-named patient's 18th birthday in which they may consent as a legal adult.

________________________________ ________________________

Signature of Parent/Guardian Date

____

Relationship to Patient