BRUSH DENTAL

CONSENT TO TREAT PATIENT WITHOUT PARENT/LEGAL GURADIAN PRESENT

PATIENT NAME _____ **Birth Date:** _____/_____/_____
Allergies:

_____

Current Medications:

_____

Chronic Conditions:

_____

LIMITATIONS

Identify any specific limitations on the kinds of dental services/treatment for which this authorization is given. If none, please state "NONE".

_____

AUTHORIZATION

_____ The Parent/Guardian of this patient consents to any future dental treatment that may be required. Therefore, by signing this consent form, this no longer requires that the parent be contacted each visit before treatment is rendered. This consent may be revoked if BRUSH DENTAL receives a letter stating the revoked consent at least 10 (ten) business days before next appointment.

_____ I understand that it is Brush Dental policy that Minors must be accompanied by a parent or legal guardian to a visit unless the child is 13 years of age or older and I have signed this consent.

_____ I hereby authorize my child _____ or

Name: _____ ***Phone:*** _____ ***Relation*** _____

Address: _____ to bring my child to his/her appointments if I am unable to attend. I understand that medical/dental advice will be replayed to them on my behalf. I understand and agree that signatures and dates on this form will not expire without written notice or when a minor becomes the age of 18 and that a photocopy of this form is considered valid as original.

_____ This limited authorization gives Brush Dental authority to release the above-named Minor's medical information to the designated agent as necessary to allow the agent to make an informed decision regarding consent to treatment of the Minor.

_____ Parent/Guardian also consents to the payment of any fees that may be incurred from treatment done in office. Parent/ Guardian knows that the full payment of co-pays, or full amount for treatment is due at time of service.

_____ I understand that if I do not have insurance on the date of service, payment in full will be expected at the time of the service as Brush Dental does not accept payments.

_____

PRINTED NAME OF PATIENT, PARENT, or GUARDIAN **DATE**

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN **PHONE NUMBER**