

Welcome to
CHILDREN'S DENTAL
CENTER OF MADISON, S.C.



Authorization for Non-Parent/Guardian Consent

Our office encourages that all parents or legal guardians accompany their child to each dental appointment. If the parent is unable to accompany the child for their initial dental appointment or recall visit, please fill out this form. This consent, however, does not extend to dental treatment under oral conscious sedation or general anesthesia. If we are unable to obtain consent and /or information needed, we will need to reschedule your child's appointment.

Child(ren) name(s):

Authorized Caregiver's name

Relationship to child

Caregiver's phone number _____

I give permission for the above-named Caregiver to accompany the above-named child(ren) to their initial examinations and subsequent recall visits. Treatment to be performed includes routine pediatric dental services (examination, cleanings, radiographs, fluoride treatment, sealants and any additional treatment that has been explained to me.) The initial patient registration forms, including all medical and dental histories, must be completed by the parent or legal guardian.

This consent shall be effective from the date of signature until revoked by the parent or legal guardian.

I can be reached at this phone number _____.

Parent/Guardian Signature

Date

Printed Name of Parent/Guardian
