HAXTUN DENTAL CARE
115 S. Colorado Ave.
Haxtun, CO 80731
970-774-7999

CONSENT FOR DENTAL TREATMENT OF MINORS IN ABSENCE OF PARENT/LEGAL GUARDIAN

(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 care provider. If no changes, please check box next to child's name and initial.

Patient's Name: ____

DOB: ________________________

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This consent serves as permission for treatment by Haxtun Dental Care for the above-named child. The individual bringing my child to the appointment is: ____________________________ .

I give my authorization for all dental treatment including routine procedures that may be required during my absence: x-rays, exams, prophy, preventive procedures including . sealants, fillings, as well as emergency dental treatment such as extractions, for the above-named child. I agree to pay for all services provided to my child, if not covered by insurance.

This authorization shall remain effective:

__ One (1) year from date signed below

OR

__ Until ______________________________________ (Month, Day, Year)

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This authorization will remain in effect until the date stated above unless I revoke this authorization in writing and submit it to Grimes Pediatric Dentistry prior to this date.

Parent/Legal Guardian Name ____

Signature ____

Phone Number __________________________ Date _______________________________

Please return with child at time of appointment.