Permission to Treat by Parents or Legal Guardian
For Minor Children

I hereby authorize consent for dental examination and treatment, to include but not limited to, obtaining x-rays, medication administration and patient education by the healthcare providers of this facility. I understand that I have the right to be informed by my dentist of the nature and purpose and any proposed procedure, alternative methods of treatment and an explanation of the risks and benefits of both. This form is not a substitute for that explanation.

The consent of a parent or guardian is required for the treatment of minors. A minor is any person under 18 years of age. This practice requires that a minor be accompanied by a parent or guardian. This consent gives us permission to treat the patient for those items specified below. This consent will remain in effect for one (1) year, or until you notify us otherwise.

As the parent or guardian, I _____, give permission for

_____ to be seen at The Dentists at North Cypress according to the guidelines below.

- ☐ May come to the office with _____.

I give my permission for the following:

- ☐ Routine examinations and prophylaxis (cleanings)
- ☐ X-rays
- ☐ Fluoride treatments
- ☐ Emergency treatment of pain
- ☐ Administration of anesthetic
- ☐ Treatment as proposed on the attached treatment plan

I can be contacted at _____ or _____ if additional information is needed during the exam.

_____ _____
Parent or Legal Guardian Signature Date

_____ _____
Witness Signature Date

Minor's Name: DOB: