CAÑON FAMILY DENTAL

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Preauthorization to Treat Minors Consent Form

Purpose: this form may be used to allow an adult other than a parent or legal guardian to serve as proxy decision maker for routine medical care and services at Canon Family Dental.

For some families, it may be more convenient to have prior authorization in place that allows routine medical and dental care to be delivered to minors if parent or legal guardian cannot be present to provide consent. If you would like to have such a preauthorization in place, please review and complete the following form authorizing an alternate decision maker to consent to and be involved in dental treatment services and care of a minor child.

Authorization: (Appointed person must be 21 years or older)

I hereby appoint: _____ _____

Name Relationship

As a proxy decision maker to consent to and authorize routine health care treatment and services for my child(ren) listed below.

Routine medical/dental care and interventions may include, but are not limited to: Medical evaluation, x-rays, dental cleanings, fluoride treatment, administration of nitrous and anesthetics, preventative and restorative treatments, minor suturing of lacerations, removal of simple cysts, incision and drainage of abscesses.

I hereby empower and grant proxy decision maker appointed above permission to consent to and authorize routine medical or dental care as may be deemed necessary or advisable. *(more than one child may be listed)*

Child Name: _____ DOB: _____

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Parent/legal Guardian contact information for questions regarding treatment:

Parent's name: _____ Parent's name: _____

Daytime phone: _____ Daytime phone: _____

Evening phone: _____ Evening phone: _____

Cell Phone: _____ Cell Phone: _____

Limitations:

Identify and specify limitations on types of medical and dental services for which authorization are not given. (Please state "none" if this does not apply)

_____

I hereby indemnify and hold harmless Canon Family Dental and all their officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporation, successors, heirs, assigns from any and all liability for acting in reliance on this authorization. Also agree to accept financial responsibility for all care and services delivered pursuant to this authorization is valid for one year following the date signed below unless with drawn in writing to Canon Family Dental or restricted by time frame as noted above. Only one parent. Guardian's signature is required.

_____ _____

Signature of Parent or Legal Guardian Date