

Advanced Dental Care of Toledo

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Parental Authorization for Treatment of a Minor

Grandparent or Other Authorized Adult

Minor Patient

Child's Full Name: _____ Date of Birth: _____

Parent or Legal Guardian

Name: _____ Relationship to Child: _____

Phone: _____ Alternate Phone: _____

I am the parent or legal guardian of the minor child named above. I authorize the following individual to accompany my child to dental appointments and, subject to the limitations below, to communicate with the dental office and consent to dental treatment on my behalf.

Authorized Adult

Name: _____ Relationship to Child: _____

Phone: _____

Authorization

I authorize the individual named above to consent to the following dental care for my child:

- ☐ Dental examinations and consultations
- ☐ Dental X-rays and diagnostic procedures
- ☐ Dental cleanings and preventive treatment, including fluoride and sealants
- ☐ Restorative treatment, including fillings
- ☐ Administration of local anesthetic
- ☐ Emergency dental treatment when reasonably necessary
- ☐ Other: _____

The following procedures require my direct consent unless specifically authorized below:

- ☐ Extractions ☐ Root canal/endodontic treatment ☐ Crowns
- ☐ Nitrous oxide ☐ Oral sedation ☐ Other surgical or irreversible procedures

I specifically authorize the following additional treatment, if recommended:

Consent Terms

I understand that this authorization does not replace any procedure-specific informed consent required by the dental practice. The dentist may require direct consent from me or the child's legal guardian before performing treatment when appropriate.

I authorize the dental office to discuss information reasonably necessary for my child's dental care with the authorized individual named above.

Emergency Contact

If additional treatment becomes necessary, please attempt to contact me at:

Primary Phone: _____ Secondary Phone: _____

If I cannot be reached, the dental office should:

- ☐ Proceed only with treatment necessary to address an immediate dental emergency.
- ☐ Contact me before performing any treatment beyond what is specifically authorized above.

Duration of Authorization

VALID FOR SIX (6) MONTHS FROM THE SIGNATURE DATE.

This authorization expires six (6) months after the date the parent or legal guardian signs this form below.

I understand that I may revoke this authorization in writing at any time, subject to treatment already provided in reliance upon this authorization.

I certify that I have the legal authority to consent to dental treatment for this minor and to grant the authorization described above.

Parent/Legal Guardian Signature: _____

Printed Name: _____ Date: _____

Witness/Office Representative: _____ Date: _____

Office Use

Identity of authorized adult verified by:

- ☐ Driver's License / Government-issued ID ☐ Known to practice
- ☐ Other: _____

Staff Initials: _____ Date: _____