



Chaperone Consent Form

Date: _____

Patient Name: _____

Patient's Birth Date: _____

I, _____ give _____ permission to consent to diagnostic aids including x-rays, models, photographs and treatment as well as update patient's health history to the following person:

Chaperone Name: _____

Chaperone Phone Number: _____

Chaperone Date of Birth: ____/____/____ [Must be 18 years of Age or Older]

Relationship to Minor: _____

Chaperone Signature: _____ Date: _____

Please keep this on File for all future appointments (consent is valid for 1 year)

Disclaimer: Cash, and/or Visa/Master-Card accepted. The responsible party is ultimately responsible for any and all fees incurred. If dental insurance is filed, the estimated contract co-pay is due in full at the time services are rendered. The responsible party is further responsible for any amount discounted or disallowed by the insurance company, except in the case where the amount is a contractual discount. If the insurance does not remit payment within 60 days, the full balance becomes the obligation of the responsible party, and it is then the responsible party's burden to collect from the insurance carrier. If an account should ever require collections action, the responsible party will be obligated to pay any and all collection fees.

☐ I understand and accept the above disclaimer as the responsible party.

Parent/Guardian Acknowledgement/Acceptance: I agree to pay according to the conditions and limitations of the policy at the time services are rendered. The signature below also constitutes my agreement as the responsible party that the insurance shall submit payment to Griffith Pediatric Dentistry. Patient (s) Health history form must be updated and completed. Please note picture identification will be needed on the day of service. This consent is only honor for 1 year from date of service.

Printed name of Parent/Legal Guardian

Phone Number

Signature of Parent/Legal Guardian