WINDSOR PEDIATRIC DENTISTRY

JILL SHONKA, DDS, PC

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR WHEN LEGAL GUARDIAN and/or PARENT(S) IS UNABLE TO BRING PATIENT

Please print or type:

I, _____, parent or guardian of _____, a minor, do hereby authorize the following name(s); (example: name of friend, grandparent, aunt, uncle, neighbor, etc.)

a._____
b. _____
c. _____

as my agent(s) to consent to any x-ray examination, anesthesia, medical evaluation and/or treatment, surgery evaluation and/or treatment, diagnosis or care which is deemed advisable by and is to be rendered under, the general or special supervision of a licensed physician. This authorization includes hospital admission if such is deemed necessary by the physician. It is understood that this authorization is given to provide authority and power on the part of my aforesaid agent(s) to give specific consent to any and all such evaluation, diagnosis, office treatment, anesthetic administration or surgical treatment(s) which a physician, in the exercise of his/her best judgment, may deem advisable.

This authorization also grants to my agent(s) the power to sign for release of information to any third party payers who may be responsible for part or all of the cost of the services provided. This authorization shall remain effective from _____/_____/_____ to _____/_____/_____, unless sooner revoked in writing delivered to said agent(s).

_____/_____/_____ _____

Date Signature of parent, guardian or other legal representative

PATIENT INFORMATION FOR MINOR LISTED ABOVE

Patient's Name:_____ Date of Birth: _____/_____/_____
Home Address:_____
_____
Current Medication(s):_____
Allergies:_____
Parent or Guardian Name(s): (1)_____
Relationship_____
(2)_____
Relationship_____
Primary Insurance Company:_____
Person Who Carries This Insurance:_____
Address (if different from above):_____
_____
Insurance ID Number:_____Group Number:_____