Livingston Pediatric Dental Associates

CONSENT TO TREAT MINORS

I (We) the undersigned parent, parents, or legal guardian of _____ DOB ___/___/___, a minor, do hereby authorize and consent to any x-ray, examination, anesthetic, dental diagnosis, and performance of all recommended treatment which is deemed advisable by and is to be rendered under the general or special supervision of any dentist of Livingston Pediatric Dental Associates. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority and power to render care which the aforementioned dentists in the exercise of their best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but any of the above treatments will not be withheld if the undersigned cannot be reached.

I (we) understand the importance of my (our) presence during appointments, but in the case of my (our) unavoidable absence, I (we) give permission for the following person(s) to provide necessary supervision:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

I (we) acknowledge that it is my (our) responsibility to immediately notify Livingston Pediatric Dental Associates of any changes to the above information.

_____ ___/___/___ _____
Signature of Legal Guardian Date Relationship to Patient

_____ ___/___/___ _____
Signature of Legal Guardian Date Relationship to Patient

Please note: Livingston Pediatric Dental Associates may require copies of legal guardianship papers, if applicable. Please know that all payments are due at the time of service. If you have dental insurance, deductibles, co-payments, and portions of your bill that insurance does not cover are due at the time of service.