Consent to Treat Patient When Parent/Guardian Is Away from Office

Patient's Name(s) _____

We know there are times when your child is receiving treatment at our office that you the parent/guardian need to step away from the office to attend to other needs. Our office recognizes this but want to make you aware of our policy concerning this.

- Update medical history form before leaving the office. (If there are any changes)
- Provide us with a cell phone/emergency contact number where you can be reached during the time you are away from the office.
- We expect that you will return by the stated end of the appointment time and come in to the office to check in with the front desk and pick up your child.

_____ This consent is for today only.

_____ This consent is for all future dental and/or ortho appointments.

Occasionally there are changes that need to be made to the treatment once Dr. Jones or Dr. Harrison begins

_____ I authorize Dr. Jones or Dr. Harrison to complete any additional treatment. We will make every attempt to notify you of any changes or unexpected treatment.

_____ I do not authorize any additional treatment to be completed.

Signature _____ Print name_____

Cell Phone/Emergency # _____ Date_____