Brink & White pediatric dental Associates

joshua a. brink, dds jason e. white, dds emily m. sheppard, dds

Consent to Treat Unaccompanied Minor (age 16-18)

I, _____, **(Parent / Legal Guardian)** hereby confirm that I have provided Brink & White Pediatric Dental Associates with all the necessary medical history information for _____ **(name of minor child)** _____ **(DOB)**. I have signed the required paperwork and it is on file at Brink & White Pediatric Dental Associates. In the event that I cannot accompany the above named minor child to his/her visit on _____ (**date of appointment)**, I hereby give permission for the doctors and staff at Brink & White Pediatric Dental Associates to treat him/her. I understand that I must be available by phone during the time of treatment to speak with the doctor or staff should any issues/questions arise.

I understand that all proposed treatment will be recorded in my child's record. A copy of my child's treatment plan for their next visit will be sent home with my child. I understand this treatment plan may not include all diagnosed treatment. I understand that it is my responsibility to call Brink & White Pediatric Dental Associates with any questions I may have and to schedule my child's next appointment.

I understand the Estimated Patient Portion for services rendered at my child's appointment is due before the appointment can begin and that it is my responsibility to make payment arrangements or send payment with my child.

I understand that if payment arrangements are not made or the Proposed Treatment Plan is not signed and returned, my child will not be seen and I will be charged a failed appointment fee for the visit.

I understand that this permission is only good for the appointment date noted above.

X _____

Printed Name of Parent/Legal Guardian

X _____

Signature of Parent/Legal Guardian Date

January 2018