Designation of Another Individual to Consent for Medical Care

It is best that children are brought for care by a parent or legal guardian. However, sometimes you may wish to have other **individuals** bring in your child, like a family member. In order for your child to be seen, we must have written authorization allowing this person to accompany your child(ren).

This form allows the individuals you choose to seek services/treatment, make decisions regarding your child's dental and vision treatment, discuss and share medical information about your child and see all necessary medical records when you are unable to attend the visit with your child.

Parent(s)/Legal Guardian(s)

Name: _____ DOB_____ Relationship to patient: _____

Name: _____ DOB_____ Relationship to patient: _____

** All parents/legal guardians should be listed.*

OPTION A

☐ I **DO NOT** authorize anyone else besides the parent(s)/legal guardian(s) listed above

OPTION B

I authorize the following person(s) to take my child to and from his/her appointments, and to make all necessary decisions.
(Please check all that apply below):

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

The individual(s) you name must be at least 18 years of age or older

MUST MAKE SELECTION

- ☐ Discuss financial information (insurance, copayments, past due balance, account history).
- ☐ **DENTAL**: Escort child to appointment and make decisions that may include examination, radiographs, prophylaxis (dental cleanings), periodontal treatment & fluoride treatment, consent to use of nitrous oxide analgesia (laughing gas), extractions and restorative appointments (including but not limited to fillings, stainless steel crowns and pulpotomies). ***General Anesthesia, IV Sedation and Oral Sedation appointments are excluded regardless of procedures completed and require a parent/guardian to be present or when applicable parent/guardian consent.**
- ☐ **ORTHODONTIC**: Escort child to appointment and make orthodontic decisions that may include radiographs, appliance checks, treatment compliance and retainer checks. *** Initial visits, changes in treatment plan, appointments where braces are being put on or taken off, appointments where contractual changes are being made, informed consent is being updated and as requested by the provider are excluded and require parent/guardian to be present or when applicable parent/guardian consent.**
- ☐ **VISION**: Escort child to appointment and make vision decisions that may include but not limited to; preliminary testing, pupil dilation, exam, choosing eyeglasses, and allow pick up of glasses and/or contact lenses.

If your child is 16 years of age and older, you can elect to allow them to pick up their own glasses and /or contact lenses

☐ Yes, allow such pickups ☐ No, do not allow such pickups

Patient's Name (printed): _____ Date of Birth: _____

Parent/Guardian Signature: _____ Date: _____

If Completing Outside of the Practice, a Witness (other than the designated individual) is Required:

Witness Name (printed): _____ Phone number: _____

Witness Signature: _____ Date: _____

This form expires one year from signed date.

Changes may be made by a parent/legal guardian with any staff member at any time.

Changes are effective when received by the practice.

********FOR OFFICE USE ONLY**********

THIS FORM SHOULD BE PROVIDED TO EACH SELECTED LOB ☐ DENTAL ☐ VISION ☐ ORTHO