Pediatric Dental Specialists
Unaccompanied Minor Form

I am the parent/legal guardian of (print name(s)_____,
who is under 18 years of age. Due to (reason) _____, I may not be able to accompany my child when he/she requires dental services. I authorize the health care providers of Pediatric Dental Specialists, P.C., to provide my child with dental services as indicated when accompanied by any of the following individual(s). I authorize the below listed individual(s) to make any dental and financial decisions for my child, including, but not limited to, appointments using sedative medications, nitrous oxide, exposing dental radiographs, and application of fluoride. I understand financial arrangements must be made prior to any dental treatment rendered to my child if brought by the below listed individual. Pediatric Dental Specialists will make every effort to communicate treatment needs with the below listed individual(s). If changes in dental treatment occur, I authorize the dentist to make treatment changes during the procedure in the best interest of my child. The below listed individual(s) will be informed of any changes after the completion of dental services.

1.)_____ _____ _____
Name Relationship to child Phone #

2.)_____ _____ _____
Name Relationship to child Phone #

In case of an emergency during my absence, please contact: Name (print): _____

Relationship to child_____ Telephone: _____

I have read and understand the contents of this consent form, which I voluntarily sign. I further understand that this consent form will be valid and remain in effect until I revoke it in writing.

_____ Date _____
Signature of Parent/Legal Guardian of Minor Patient

Name of Parent/Legal Guardian (please print) _____
Address: _____
Telephone Number: (cell)_____ (work) _____

Section below is for patients of driving age:

I give consent for my child to drive him / herself to dental appointments unaccompanied by an adult. I authorize the health care providers of Pediatric Dental Specialists to render dental treatment. I understand financial arrangements must be made prior to any dental treatment rendered to my child. If changes in dental treatment occur, I authorize the dentist to make treatment changes during the procedure in the best interest of my child. As parent or legal guardian, I will be informed of any changes after the completion of dental services.

I have read and understand the contents of this consent form, which I voluntarily sign. I further understand that this consent form will be valid and remain in effect until I revoke it in writing.

_____ Date _____
Signature of Parent/Legal Guardian of Minor Patient

Name of Parent/Legal Guardian (pleased print) _____
Address: _____
Telephone Number: (cell)_____ (work)_____

In case of an emergency during my absence, please contact: Name (print): _____

Relationship to child_____ Telephone: _____