



# S C R I P P S

FAMILY & COSMETIC DENTISTRY

## Minor Child Consent

I am the parent, guardian, or personal representative of \_\_\_\_\_ and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize Scripps Family & Cosmetic Dentistry to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the dentist, whether or not I am present when the treatment is rendered. ( )

*In the event of an emergency, I authorize Scripps Family & Cosmetic Dentistry to make any decisions with regard to the health, safety, welfare and medical necessity of the above named child. I understand that any decisions made by Scripps Family & Cosmetic Dentistry will be made in the best interest of the child.* ( )

I understand that I may revoke this authorization at any time, without notice. I understand that I must submit in writing my request. I further understand that periodically I may be required to update paperwork, and a separate consent form. I will need to make arrangements BEFORE the dental appointment to complete these. ( )

Parent Guardian Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Relationship to child \_\_\_\_\_

Date	Service Rendered	Notes