Grand River
Pediatric Dentistry

Name: _____ Birthdate: _____

Designation of Another Person to Consent to Dental Care & Access Health Information

It is best that a parent or legal guardian accompanies children to each visit at Grand River Pediatric Dentistry. However, we understand there may be times when someone other than you takes care of your child. If your child must be seen at those times, we require signed consent to provide dental care. The parent or legal guardian must accompany the child to the initial visit or this form must be dropped off in person.

This consent form allows the person you choose to seek dental treatment and sign consent for your child when you are unable to come with your child.

- The person you name must be 18 years of age or older.
- Please use a separate form for each child.
- Photo ID will be required at the appointment.
- Please be aware that all copays and deductibles will be due at the time of appointment.

I/We, _____ are the parent(s)/guardian(s) of _____.
I/We appoint the following persons to seek dental treatment consent for my child without having to contact me:

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

This permission includes exam, x-rays, cleaning, fluoride treatment, administration of local anesthetic, use of nitrous oxide and any other dental treatment deemed necessary by Grand River Pediatric Dentistry. I accept financial responsibility for treatment completed on behalf of my child, however all copays are due at time of service.

This consent shall:

☐ remain in effect for one calendar year.
☐ be in effect for the specific time frame given here _____.

Name:_____

Signature: _____ Date: _____

Parent/Guardian's Contact Number: _____