SMILES
AUSTIN | DRIPPING SPRINGS
Orthodontics and Pediatric Dentistry
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CONSENT/AUTHORIZATION FOR DENTAL TREATMENT OF A MINOR

Patient Name: _____ Date of Birth: _____

All minors seeking dental treatment must be accompanied by a parent/legal guardian during the initial office visit. After the initial appointment, a minor may be seen for treatment only with written authorization from the parent/guardian under the conditions specified in this consent. If the parent/legal guardian cannot attend the appointment, the following instructions that you select will be adhered to in the treatment of the minor patient (check all that apply):

- ☐ the consent for to sign any and all forms required to give permission to Smiles of Austin/Smiles of Dripping Springs to treat the dental needs of my child,
- ☐ the consent to the dental practice to discuss finances (treatment charges, account balances, next visit charges),
- ☐ the consent to the dental practice to discuss my child's future dental treatment needs (ie. treatment plans)
- ☐ the consent to sign my child's treatment plan once it has been presented by the dental staff. I understand this does not obligate me to the treatment, only that the office has informed me or my representative of the dental needs of my child,
- ☐ the consent to schedule future dental visits for my child.

If you need to send your child to their appointment with an adult other than yourself/legal guardian, please complete this section:

I appoint the following adult _____, whose relationship to the minor is_____, to consent to dental treatment which is deemed necessary by Smiles of Austin / Smiles of Dripping Springs as authorized herein. A parent/legal guardian may appoint another adult to accompany the minor patient to the appointment. If the parent/legal guardian is not available, the Texas Family Code allows only certain adults to consent for medical treatment to minors if parental consent cannot be obtained. These are: a grandparent, an adult brother, sister, aunt or uncle, and any adult who has actual care, control, and possession of the minor and has written authorization to consent from the parent/legal guardian.

I, _____, am the parent/legal guardian of the minor child _____. I have the legal right to consent for medical treatment for this patient. I hereby authorize Smiles of Austin / Smiles of Dripping Springs to provide dental treatment as indicated above. **I understand this consent will be valid for one year or until I rescind this agreement in writing.**

*** I understand I am responsible for all charges or fees incurred and co-payments must be made at the time of service as our financial policy states. We will gladly process payments over the phone if a credit card is used.**

_____ _____ _____

Parent/Guardian Signature | Parent/Guardian Printed Name | Date