HOUSE DMD
FAMILY DENTAL

Proxy Authorization to Treat Minor

A child under the age of 18 must have a guardian's written consent for treatment. Will anyone else be allowed to bring your child(ren) to an appointment in this office and make dental decisions on your behalf: Y/N

Please list the names and phone numbers of those you authorized to serve as a proxy for your child(ren) dental care:

Name	Relationship	Phone Number

Authorization: I hereby empower and grant the proxy decision maker appointed above permission to consent to and authorize House Family Dental PC to deliver routine medical and dental treatment and services to my child. Routine medical/dental care and interventions may include, but are not limited to: medical evaluations, physical exam, x-rays, lab work (examples include: dental cleanings, fluoride treatments, preventative and restorative dental treatments, liquid nitrogen, suturing of laceration, removal of simple cysts, and incision and drainage of abscesses).

Limitations: Identify any specific limitations on types of dental services for which this authorization is given. (Please state "none" if this does not apply.)_____-
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I hereby indemnify and hold harmless House Family Dental and all their officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization is valid unless withdrawn in writing to House Family Dental. Only one parent/guardian's signature is required.

_____ _____

Signature of Parent or Legal Guardian **Date**

Preauthorization to Treat Minors Consent Form

Purpose: This form may be used to allow minors of legal driving age (16 or older) to receive routine dental care and services at House Family Dental PC offices without a parent or proxy present.

Please list the names and date of birth of the child(ren) you authorize to consent for treatment. (Must be 16 or older.)

Name of child 16 or older	DOB

Authorization: I have the legal right to preauthorize House Family Dental PC and its personnel to deliver routine medical and dental treatment and services to my child. Routine medical/dental care and interventions may include, but are not limited to: medical evaluations, physical exam, x-rays, lab work (examples include: dental cleanings, fluoride treatments, preventative and restorative dental treatments, liquid nitrogen, suturing of lacerations, removal of simple cysts, and incision and drainage of abscesses).

Limitations: Identify any specific limitations on types of medical or dental services for which this authorization is given. (Please state "none" if this does not apply.)_____

I hereby indemnify and hold harmless House Family Dental and all their officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization is valid for two years following the date signed below unless withdrawn in writing to House Family Dental or restricted by time frame as noted above. Only one parent/guardian's signature is required.

_____ _____

Signature of Parent or Legal Guardian **Date**