Patient Name:

Medical Treatment Authorization and Consent Form

** While we encourage a parent/legal guardian to be present for the child's first visit to our office, we understand this may not always be possible. If you will not be accompanying your child, this form must be completed and emailed to Office@DrSmiLee.com prior to the visit and the accompanying adult must provide matching photo ID at the time of the appointment and be completely aware of the child's medical history. We ask that the parent/legal guardian be available by phone. **

The following form is designed for those situations where minors are unaccompanied by either parents or legal guardians. This "Medical Treatment Authorization and Consent Form" gives authority to a designated adult to arrange for medical/dental care for a minor. This is extremely important, in that, medical/dental care cannot be provided to a minor without approval by the parents or legal guardians, unless there is written consent authorizing an agent to give approval.

The undersigned do hereby authorize:

(adult who will accompany minor to dental appointment AND their relationship to the minor) as he/she may designate as agent for the Undersigned to consent to any radiographic, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care for the above named minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and/or surgeon, licensed under the Provision of Medicine Practice Act or of any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, or elsewhere.

As the adult accompanying the minor is authorizing medical/dental treatment, it is very important that they have complete knowledge of any medical conditions, current medications, and existing allergies of the minor. A medical and dental history will have to be filled out and updated each visit on behalf of the minor.

While we strive to provide the most accurate treatment plan cost estimates, sometimes situations arise that necessitate deviations in the treatment plan that may cause the overall cost of treatment to increase or decrease. I authorize the undersigned to make financial decisions and arrangements to cover the cost of treatment rendered.

This authorization is effective as of date signed and will be added to the minor's records and will remain effective until otherwise requested by parent or legal guardian.

Parent/Legal Guardian's Name:	Date: