

PREAUTHORIZATION TO TREAT MINORS CONSENT FORM

Purpose: This form may be used to allow minors under eighteen(18) years to receive routine care and services at Dental Associates of Newton Falls, Inc. without a parent or proxy present.

For some families, it may be more convenient to have prior authorization in place that allows routine dental care to be delivered to minors if a parent or legal guardian cannot be present to provide consent. If you would like to have such a preauthorization in place, please review and complete the following form authorizing treatment for your minor child in advance.

AUTHORIZATION:

I have the legal right to preauthorize Dental Associates of Newton Falls, Inc. and its personnel to deliver routine dental treatment and services to my child. Routine dental care and interventions may include, but are not limited to: preventive care such as; an exam, x-rays, dental cleanings, and fluoride treatments, or local anesthetic and restorative dental procedures.

I request and authorize Dental Associates of Newton Falls, Inc. and its personnel to deliver dental care to my child listed below as may be deemed necessary or advisable in the diagnosis and treatment of the minor child:

Name: _____ DOB: _____

LIMITATIONS:

Identify any specific limitations on the kinds of dental services for which this authorization is given. (If none; state "none") _____

Parental contact information for questions regarding treatment of the minor child:

Parent's Name: _____	Parent's Name: _____
Daytime Phone: _____	Daytime Phone: _____
Evening Phone: _____	Evening Phone: _____
Cell Phone: _____	Cell Phone: _____

I hereby indemnify and hold harmless Dental Associates of Newton Falls, Inc. and its personnel from any and all liability for acting in reliance on this authorization. I also agree financial responsibility for all care and services delivered pursuant to this authorization. This authorization is valid for one year (1) following the date signed below unless withdrawn in writing to Dental Associates of Newton Falls, Inc. or restricted by time frame as noted above. *Only one parent's signature is required.*

Signature of Parent or legal Guardian

Signature of Parent or Legal Guardian

Date

Date