



ALSBURY DENTAL
making beautiful smiles

TREATMENT OF MINOR WITHOUT PARENT/GUARDIAN CONSENT FORM

I, _____, give Alsbury Dental Care, permission to treat my child,
Parent/Guardian name

_____, while I am not present.
Child's Name

The individual bringing my child to the appointment is named, _____ and is at
Adult accompanying child

least eighteen years of age and is the patient's _____. I also give this
Relationship to Child

individual permission to make decisions regarding my child's dental treatment which may include cleaning,

x-rays, examination, localized anesthesia and nitrous oxide. If there is a change in treatment once it has

started we will move forward with what is in the best interest of the patient. If this concerns you then

we ask that you stay with your child during duration of treatment. I understand payment is expected at the

time of treatment.

Parental contact information of questions regarding treatment of the child:

Parent's Name: _____

Contact Info: (Cell) _____ (Home) _____ (Work) _____

Mailing Address: _____

Signed: _____ Date: _____

Relationship to Patient: _____