Green Apple Pediatric Dentistry, PLLC
11601 US HWY 290 W, Suite B105
Austin, TX 78737

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR WHEN LEGAL GUARDIAN and/or PARENT(S) IS UNABLE TO BRING PATIENT

Please print or type:
I, _____, parent or guardian of _____, a minor, do hereby authorize the following name(s): (example: name of friend, grandparent, aunt, uncle, neighbor, etc.)

A._____
B._____
C._____

The above-listed individual(s) will act as my agent(s) to consent to x-rays, dental examination and prophylaxis (dental cleaning). If a treatment plan has been previously signed by a legal guardian, then this form will give the above individual(s) the ability to consent for changes in treatment which the doctor, in the exercise of her best judgment, may deem advisable. This may include: local anesthesia, nitrous oxide sedation, composite (white) and amalgam (silver) restorations, extractions, pulpal therapy or other treatment deemed necessary. **For administration of oral conscious sedation or general anesthesia, the parent or legal guardian must be present for treatment and remain in the office for the full duration of such appointment.**

PATIENT INFORMATION FOR MINOR LISTED ABOVE

Patient's Name: _____ Date of Birth: _____/_____/_____
Home Address: _____
Current Medication(s): _____
Allergies: _____
Recent Health Changes: _____
Parent or Guardian Names(s): (1) _____
Relationship: _____
(2) _____
Relationship: _____
Primary Insurance Company: _____
Person Who Carries This Insurance: _____
Address (if different from above): _____
Insurance ID Number: _____ Group Number: _____