



UNACCOMPANIED MINOR FORM

Many times parents will send children who are old enough to drive to the office without the parent or legal guardian present. If your child does now, or will be coming to the office by themselves in the future, please sign the consent below.

If we do not have this consent on file, except in emergency situations, your child's appointment may need to be rescheduled.

I understand that by signing below I authorize the following procedures to be performed without my presence as deemed necessary by the dentist and have read and understand the possible risks and complications of each procedure.

X-Rays & Examination

I understand that my child will be receiving a dental examination from a state licensed and board-certified pediatric dentist. I understand that x-rays may be taken of my child's teeth as part of the necessary requirements to complete a thorough and comprehensive examination.

Medical Photography

Consent I consent to digital photographs and x-ray images of my child to be used exclusively within their medical record for the purposes of identification and dental treatment.

Dental Cleaning and Fluoride Treatment

I authorize the Doctor and/or the staff members to clean my child's teeth. I understand that the application of fluoride is part of the standard of care for children and helps prevent cavities.

Drugs and Medication

I understand that antibiotics, analgesics and topical compounds can cause allergic reactions even with no prior known history. Allergic reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I have informed the dentist, to the best of my knowledge, of any adverse reactions my child has had.

I understand that all of the above treatments are the standard of care in pediatric dentistry. It is my responsibility to inform the staff during the registration process if I choose to decline any of the above treatments. I attest that the information I have provided on this form is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

I, the undersigned, as the parent or legal guardian hereby authorize both diagnostic and dental treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of the minor without my presence.

The Dentist, appropriate staff, and Sunrise Pediatric Dentistry, and its employees shall not be responsible in any way for the consequences from said diagnostic and dental treatment and are hereby released from any and all claims and causes of action that may arise, grow out of, or be incident to such diagnosis or treatment in so far as the law allows and provided that these services are performed with ordinary care and to the best of their ability.

This consent expires in 1 year unless revoked in writing. As parent/legal guardian, I give consent for my child to be treated if I have not accompanied him/her.

Parent's Name: _____

Relationship to Child: _____

Child's Name: _____

Date: _____

Signature: _____