CAREGIVER CONSENT FORM FOR TREATMENT OF A MINOR

It is the policy of Green Hills Pediatric Dentistry that all minors be accompanied by a parent or legal guardian for their dental visits. We understand, however, that there may be times when you prefer another caregiver to accompany them.

A parent or guardian **MUST** be present for your first visit with our office. After this initial appointment, a minor may be seen for **routine** six-month check-ups and cleanings if brought by another caregiver. That person may be a baby-sitter, older sibling or other family member and must be 18 years or older. If we do not have this consent on file, except in emergency situations, we reserve the right to reschedule your child's appointment. If this caregiver has Power of Attorney and/or legal decision-making rights for your child please bring that documentation to your child's appointment so that we have it on file.

I, the undersigned, as the parent or legal guardian hereby authorize the below named caregiver(s) to be present for my child's routine dental visits:

Name of caregiver: Relationship to child:

_____ _____

Name of caregiver: Relationship to child:

_____ _____

Name of caregiver: Relationship to child:

_____ _____

In the event of any issues or concerns, I understand that a reasonable attempt will be made to contact a parent or legal guardian. However, if I'm not available, I authorize the above person to make the necessary decisions on my behalf.

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 Dr. Brittany Adamiak and/or her 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 prevents 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.

The Dentist, appropriate staff and its employees at Green Hills Pediatric Dentistry shall not be responsible in any way for the consequences from said routine dental visits without my presence and are hereby released from any and all claims and causes of action that may arise, grow out of, or be incident to such visits 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. This form must be completed annually until the child is 18 years of age.

Parent's Name: Relationship to child

_____ _____

Child's Name: Date:

_____ _____

Signature:

_____