Authorized Representative for a Minor Child

Authorized representative of minor child:_____
Please list Step-parents if they will be attending appointments

Relationship:_____ Date of Birth:____/____/____ Phone:_____

I authorize the above listed adult to act in all capacities as this child's legal guardian-while at Valley Dental. This means that I permit them to schedule appointments, approve treatment, sign any consent, treatment plans, or have billing and procedural information disclosed to them. I may only revoke this consent with documentation from a legal entity stating that the authorized representative is not recognized by the court system & contact between them has been terminated. I recognize that once a child reaches 18-they are a legal adult and have the ability to imply consent if another individual, authorized by guardians or otherwise, accompanies them into any room within Valley Dental. As the child's legal guardian or biological parent, I will do my duty and be aware of any and all treatment that authorized representatives have approved or consented to. I will not hold Valley Dental responsible for any treatment completed or approved by the authorized representative as I understand that I have given this individual the power to make these decisions.

This will not apply to any operative appointments such as extractions, root canals, crowns or appointments that require written consent. Guardian must be in attendance or have signed consent forms prior to the appointment.

- **Only Biological parent(s) will be bringing the child(ren) unless the office is otherwise informed.**

_____ ___/___/___

Signature of Patient or Guardian Date

_____

Printed Patient Name(s)-list any and all children