Myra I. Covarrubias, DDS

3003 W. Dickman Rd
Springfield, MI 49037
(269) 962-1536~(269) 962-1950

Consent to Treat Patient~Without Parent/Legal Guardian Present

AUTHORIZATIONS:

I have the legal right to preauthorize the office of Covarrubias Family Dentistry to deliver dental treatment & services to my child. Dental care may include, but is not limited to: dental exam, dental x-rays, cleaning of teeth, &/or any services deemed necessary for meeting the dental needs of my child.

Child's Name: _____ DOB:_____
Allergies:_____
Current Medications:_____
Chronic Conditions:_____

LIMITATIONS:

Indicate any specific limitations of dental services for which this authorization is given. (If none, state "none") _____

Parental contact information for questions regarding treatment of child:

Parent's Name:_____
Contact Phone: _____

I hearby authorize_____ to bring his/herself to their own appointments if I am unable to attend. I understand that dental advice will be relayed to them on my behalf.

I hearby authorize _____ to bring my minor child to his/her dental appointments. I understand that dental advice will be relayed to them on my behalf.

I understand and agree that the signatures and dates on this form will not expire without written notice or in the case that a minor becomes the age of 18. I understand that a photocopy of this form is considered valid as the original.

Parent/Guardian:_____**Date**:_____