Children's Dentistry of Baytown
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Permission to Treat a Minor Child Who Drives Themselves without Parent/Legal Guardian Present For Dental Appointment

I, _____, I give my permission to Children's Dentistry of Baytown and staff to perform dental treatment on my child, _____, without my presence in the office. _____ (child's name) is ____ years old and will be bringing him/herself to this appointment.

I authorize Children's Dentistry of Baytown and staff to perform all dental treatment needed on my child including, but not limited to dental examinations, diagnostic radiographs (x-rays), dental cleaning, fluoride treatment, sealants, composite fillings, crowns, extractions, oral sedation, Nitrous Oxide (laughing gas) and local anesthesia.

If there is any change in the original treatment plan, Children's Dentistry of Baytown has my permission to perform that treatment regardless of my presence at the office.

In the event of an emergency, Children's Dentistry of Baytown has my permission to take any and all necessary steps to ensure the safety and well-being of my child.

If needed, my contact numbers are:

Cell: _____

Work: _____

Home: _____

_____ _____
Name of Parent/Legal Guardian (Print) Signature of Parent/Legal Guardian

_____ _____
Relationship to Patient Date of Appointment

_____
Today's Date