



TREATMENT WITHOUT PARENT/GUARDIAN CONSENT FORM

I, _____, give Arizona Pediatric Dental Care
Parent/Guardian Name
permission to treat my child, _____, while I am not present.
Patients' Name

The individual bringing my child to the appointment is named, _____
Adult accompanying child
and is at least eighteen years of age and is the patient's _____. I also give
Relationship to patient
this individual permission to make decisions regarding my child's dental treatment, medical
treatment (If necessary, should an emergency arise) and behavior management. I understand
payment is expected at the time of treatment.

Parental contact information for questions regarding treatment of this child:

Parent's name: _____

Contact Info (Cell): _____ (Home): _____
(Work): _____

Mailing Address: _____
City: _____ State: _____ Zip Code: _____

Signature: _____ Date: _____

Relationship to Patient: _____