Akoya Pediatric Dentistry
15761 Sheridan St, Suite A, Southwest Ranches, FL 33331
(954) 799-6212

Authorization for Treatment of a Minor

PATIENT FIRST NAME

(patient name)

PATIENT LAST NAME

(patient name)

DATE OF BIRTH (MM/DD/YYYY) *

MM/DD/YYYY

I,

(name of parent/guardian)

Hereby authorize other than legal parent/guardian: (must be older than 18).

NAME

RELATIONSHIP TO CHILD

NAME

RELATIONSHIP TO CHILD

NAME

RELATIONSHIP TO CHILD

NAME

RELATIONSHIP TO CHILD

To give consent for dental treatment of the above named child(ren) for any dental condition that he/she may encounter, or to bring the child(ren) to Akoya Pediatric Dentistry for routine checkups and associated procedures deemed necessary by Dr. Joanna Theodorou or Dr. Chau McGovern. I also authorize the dentist, hygienists, assistants and staff at Akoya Pediatric Dentistry to give information to the individual(s) named above regarding the diagnosis and plan of treatment, or any information necessary for the care of the above named child(ren).

- I hereby release Akoya Pediatric Dentistry of any liability regarding release of this information on the above named child(ren)
- I understand that if someone other than the above listed on this form brings my child(ren) to the dental appointment, my appointment will be scheduled for another time
- I understand that only the above listed have permission to make decisions regarding my child(ren)'s dental treatment, and it is my or other legal guardian's responsibility to notify Akoya Pediatric Dentistry of any desired changes
- I understand changes can be made by a parent or legal guardian anytime by filling out a new authorization for treatment of a minor, as these changes are not considered addendums to the existing form.
- I understand that even though I have authorized the above named to make treatment decisions regarding the above named child(ren), I will be financially responsible for this family account
- I understand that I am responsible for the payment at the time of services and should someone accompany my child other than myself, arrangements for payment must be made before scheduled appointment time.

Please initial if applicable

I HEREBY AUTHORIZE MY CHILD (AGES 16 AND ABOVE) TO RECEIVE DENTAL TREATMENT (I.E DENTAL CHECKUP, EMERGENCY VISITS, X-RAYS, CLEANING, FLUORIDE) WITHOUT AN AUTHORIZED PERSON ACCOMPANYING HIM/HER)

(Initial)

DRAW YOUR SIGNATURE INTO THE BOX BELOW *

Clear

DATE *

RELATIONSHIP TO THE PATIENT *

NAME IF NOT THE PATIENT