Consent for Caregiver

Child's Full Name: _____ DOB: _____

Child's Full Name: _____ DOB: _____

Child's Full Name: _____ DOB: _____

Child's Full Name: _____ DOB: _____

I, _____, give _____
(parent or guardian) (authorized person's full name)

permission to accompany my child to the office of Great Beginnings Pediatric Dentistry for dental appointments and also to make any necessary decisions regarding dental treatment for my child, including but not limited to

- The consent for this authorized person to sign any and all forms required to give permission to **Great Beginnings Pediatric Dentistry** to treat the dental needs of my child
- The consent to the dental practice to discuss finances (treatment charges, account balances, next visit charges) with this authorized person
- The consent to the dental practice to discuss my child's future dental treatment needs (i.e. treatment plans)
- The consent for this authorized person to sign my child's treatment plan once it has been presented by the dental staff. I understand this does not obligate me to the treatment, only that the office has informed me or the authorized representative to the dental needs of my child
- The consent for this authorized person to schedule future dental visits for my child

I understand this consent will be valid for the duration of my child's status as a patient of Great Beginnings Pediatric Dentistry, or until I rescind this agreement in writing.

Signed (parent/guardian): _____ **Date:** _____