

WESTFIELD PEDIATRIC DENTAL GROUP

(P) 908-232-1231 • (F) 908-232-5525

At Westfield Pediatric Dental Group, we understand that from time to time you may not be able to bring your child to their dental appointment. We will treat your child without you present for any and all dental procedures provided that:

1. **The parent/legal guardian is available by telephone.**
2. **Permission is given via consent form for procedures to be completed while parent is not present and indicates who would be bringing the child to their appointment or that they are sending the child to their appointment alone.**
3. **The parent/legal guardian has signed all required documentation.**
4. **The parent/legal guardian has informed our office that they will not be present during the appointment before the child comes into their appointment.**

Minor children who are able to drive themselves to their appointments must bring written documentation from their parent/legal guardian giving permission to Westfield Pediatric Dental Group to perform any and all dental procedures.

PERMISSION TO TREAT (Please Print Clearly)

I, _____, give Westfield Pediatric Dental Group permission to perform all dental treatment that my child, _____, while I am not present.

The individual bringing my child to the appointment is named, _____ and is at least 18 years of age and is the patient's _____. I also give this individual permission to make decisions regarding my child's dental treatment and behavior management techniques necessary to perform the dental treatment needed. I also give this individual permission to release any medical history information about my child. I understand that I am responsible for all charges or fees incurred and that copayments must be made at the time of service as the office's financial policy states and I can call in payment over the phone if a credit card is used.

In the event of an emergency, Westfield Pediatric Dental Group and staff have my permission to take any and all necessary steps to ensure the safety and well-being of my child.

I understand this agreement will be valid for one year or until I rescind this agreement in writing.

I understand and agree to Westfield Pediatric Dental Group's Treatment of Minor Consent Form and its terms.

Name of Parent/Legal Guardian (please print): _____

Signature of Parent/Legal Guardian: _____ Date: _____

Relationship to Patient: _____ Contact Info: (cell) _____