BURTON FAMILY DENTISTRY
MINOR PATIENT AUTHORIZATION AND CONSENT FORM

Patient Name (Minor): _____ **Date of Birth**: _____
Parent/Legal Guardian Name: _____
Phone Number(s): _____

I, the undersigned parent/legal guardian of the above-named minor patient, authorize the following individual to accompany and present my child for dental appointments at Burton Family Dentistry:

Authorized Adult Name: _____
Relationship to Minor: _____
Phone Number: _____

This authorization includes permission for the authorized adult listed above to:
• Bring the minor patient to scheduled appointments;
• Remain with the minor patient during examinations and routine dental care;
• Receive general appointment information and post-treatment instructions.

I understand and agree that:
1. Burton Family Dentistry requires that I remain available by telephone during the minor patient's appointment.
2. If there is a change in the proposed treatment plan, additional treatment is recommended, or a treatment decision must be made, Burton Family Dentistry will attempt to contact me directly before proceeding.
3. Except in the case of a medical or dental emergency where immediate treatment is necessary to prevent harm to the patient, no significant changes to treatment will be performed without my verbal consent.
4. It is my responsibility to provide current and accurate phone numbers and contact information.
5. This authorization does not transfer legal guardianship or decision-making authority beyond the scope stated herein.

Emergency Contact Number During Appointment:
_____

This authorization shall remain in effect until:
☐ The end of the current appointment only
☐ A specific date: _____
☐ Revoked by the parent/legal guardian in writing

Parent/Legal Guardian Signature: _____

Printed Name: _____

Date: _____

Witness/Office Staff Signature: _____

Date: _____