



**CONSENT FOR DENTAL TREATMENT OF MINORS IN ABSENCE OF PARENT/LEGAL GUARDIAN
(Please fill out one form per child)**

I, _____, give Laurich Dentistry permission to treat my child, _____,
Parent/ Guardian Name Childs Name

while I am not present. The individual/ individuals bringing my child to their appointment are listed below and are at least eighteen years of age.

Accompanying Adult:

Relationship to child:

_____ My child is of legal driving age and may be unaccompanied to dental appointments. I give consent for any and all dental treatment that has been previously discussed.

I give my authorization for all dental treatment, including routine procedures, that may be required during my absence: x-rays, exams, prophy, preventive procedures including fluoride, sealants, as well as emergency dental treatment such as extractions, for the above-named child. I agree to pay for all service provided to my child.

This authorization shall remain in effective:

_____ One (1) year from date signed below

Or

_____ Until _____ (Month, Day, Year)

This authorization will remain in effect until the date stated above unless I revoke this authorization in writing and submit it to Laurich Dentistry prior to this date. I also understand I will need to complete this form for each adult accompanying my child.

Parent/ Legal Guardian Signature: _____

Phone Number: _____ Date: _____

Please return to office prior to child’s appointment. If you have any questions please feel free to call the office. Ann Arbor (734)975-6700, Canton (734)453-0940, Farmington (248)553-0110 and Livonia (248)476-1960.