DES MOINES PEDIATRIC DENTAL CENTER

NON-PARENT CONSENT FORM

Des Moines Pediatric Dental Center encourages all parents or legal guardians to accompany their child to each dental appointment. If the parent is unable to accompany the child this form is provided.

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR WHEN LEGAL GUARDIAN and/or PARENT(S) IS UNABLE TO BRING PATIENT.

I, _____, parent or guardian
of_____ a minor, do hereby authorize the following name(s); (example: name of friend, grandparent, aunt, uncle, neighbor etc. Please include relationship with the name.)

a._____

b._____

c._____

as my agent(s) to consent to any x-ray examination, anesthesia, dental evaluation and/or treatment, surgery evaluation and/or treatment, diagnosis or care which is deemed advisable by and is to be rendered under the special supervision of the licensed pediatric dentist. It is understood that this authorization is given to provide authority and power on the part of my aforesaid agent(s) to give specific consent to any and all such evaluation, diagnosis, office treatment, anesthetic administration which Dr. Matthew Kubovich in the exercise of his best judgment may deem advisable.

This authorization also grants to my agent(s) the power to sign for release of information to any third party payers who may be responsible for part or all of the cost of the services provided. This authorization shall remain effective from _____/_____/_____ to _____/_____/_____, unless sooner revoked in writing delivered to said agent(s).

_____/_____/_____ _____

Date Signature of parent, guardian or other legal representative