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PARENTAL PRE-AUTHORIZATION FOR DENTAL CARE TO CHILDREN

AUTHORIZATION

I (We) request and authorize **Edgewater Pediatric Dentistry** and its personnel to deliver dental care to my (our) children listed below:

_____ _____
Name-Please Print Date of Birth

_____ _____
Name-Please Print Date of Birth

I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including x-rays.

I have received information regarding the proposed treatment for my child _____, and I wish to proceed with the recommended treatment.

Specialty Treatment Acknowledgement (if applicable)

_____ Parent's initial I understand that this procedure can also be performed by a _____ (a dental specialist).

I understand the risks and elect to have this procedure done by Dr. _____.

I understand that if any unexpected difficulties occur during treatment, I may be referred to a _____ for further care.

Signed:_____ **Date:**_____
Parent or Guardian

Signed:_____ **Date:**_____
Parent or Guardian

Signed:_____ **Date:**_____
Witness