

## Designation of Another Individual to Consent for Medical Care – Take Home

It is best that children are brought for care by a parent or legal guardian. However, sometimes you may wish to have other **individuals** bring in your child, like a baby-sitter or family member. In order for your child to be seen, we must have written authorization allowing this person to accompany your child(ren).

This form allows the individuals you choose to seek services/treatment, make decisions regarding your child's dental and vision treatment, discuss and share medical information about your child and see all necessary medical records when you are unable to attend the visit with your child.

### Legal Guardians

Name: \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

I authorize the following person(s) to take my child to and from his/her appointments, and to make all necessary decisions (please check all that apply below):

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

*The individual(s) you name must be at least 18 years of age or older*

#### MUST MAKE SELECTION

- Discuss financial information (insurance, copayments, past due balance, account history).
- Escort child to appointment and make **Dental** decisions that may include but are not limited to; examination, radiographs, prophylaxis (dental cleanings), periodontal treatment & fluoride treatment, consent to use of nitrous oxide analgesia, oral surgery, basic and major restorative appointments. **\*General Anesthesia, IV Sedation and Oral Sedation appointments are excluded regardless of procedures completed and require a parent/guardian present.**
- Escort child to appointment and make Orthodontic decisions that may include, but not limited to; radiographs, minor changes in treatment plan, appliance checks, treatment compliance and retainer checks. **\*Initial visits, an appointment where braces are being put on or taken off, contractual changes are being made, informed consent is being updated, and as requested by the doctor are excluded and require a parent/guardian present.**
- Escort child to appointment and make **Vision** decisions that may include but not limited to; preliminary testing, pupil dilation, exam, choosing eyeglasses, and allow pick up of glasses and/or contact lenses.

If your child is 16 years of age and older, you can elect to allow them to pick up their own glasses and /or contact lenses  
 Yes, allow such pickups  No, do not allow such pickups

Patient's Name (printed): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name (printed): \_\_\_\_\_ Phone number: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**This form expires two years from signed date. Changes may be made with any staff member at any time.**