Newburyport P.C. PEDIATRIC DENTISTRY
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UNACCOMPANIED MINOR FORM

Many times parents will send children who are old enough to drive to the office without the parent or legal guardian present. If your child does now, or will be coming to the office by themselves in the future, please sign the consent below.

If we do not have this consent on file, except in emergency situations, your child's appointment may need to be rescheduled.

I understand that by signing below, I authorize the following procedures to be performed without my presence as deemed necessary by the dentist and have read and understand the possible risks and complications of each procedure

X-Rays and Examination
I understand that my child will be receiving a dental examination from a state licensed and board-certified pediatric dentist. I understand that x-rays maybe taken of my child's teeth as part of the necessary requirements to complete a thorough and comprehensive examination.

Initial_____

Medical Photography Consent
I consent to digital photographs and x-ray images of my child to be used exclusively within their medical record for the purposes of identification of dental treatment.

Initial_____

Dental Cleaning and Fluoride Treatment
I authorize the board-certified and state licensed clinical staff at Newburyport Pediatric Dentistry to clean my child's teeth today. I understand that the application of fluoride is part of the standard of care for children and helps prevent cavities.

Initial_____

Medications
I understand that antibiotics, analgesics and topical compounds can cause allergic reactions even with no prior known history. Allergic reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I have informed the dentist, to the best of my knowledge, of any adverse reactions my child has had.

Initial_____

I understand that all of the above treatments are the standard of care in pediatric dentistry. It is my responsibility to inform the staff during the registration process if I choose to decline any of the above treatments. I attest the information I have provided is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

I, the undersigned, as the parent or legal guardian hereby authorize both diagnostic and dental treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of the minor without my presence.

Newburyport Pediatric Dentistry and its employees shall not be responsible in any way for the consequences from said diagnostic and dental treatment and are hereby released from any and all claims and causes of action that may arise, grow out of, or be incident to such diagnosis or treatment in so far as the law allows and provided that these services are performed with ordinary care and to the best of their ability.

As parent/legal guardian, I give consent for my child to be treated if I have not accompanied him/her.

Child's Full Name

Parent/Legal Guardian's Name (Print) **Relationship to Child**

Signature **Date**