PROXY CONSENT TO TREAT MINORS

This form may be used to allow an adult other than a parent to serve as a proxy decision maker for routine dental care and services at Riccobene Associates Family Dentistry.

For some families, it may be convenient to have prior authorization in place that allows routine dental care to be delivered to minors under the care of a proxy decision maker if a parent or legal guardian cannot be present to provide consent. If you would like to appoint a proxy decision maker, please review and complete the following form authorizing dental treatment or services for the care of a minor child.

AUTHORIZATION:

I hereby appoint _____ _____
NAME RELATIONSHIP
as a proxy decision maker to consent to and authorize dental care for my child(ren) listed below.

This proxy extends to care deemed necessary by the dentist(s) to treat the conditions present. This consent includes, but is not limited to, routine preventive and restorative procedures. I understand that treatment recommended and rendered is based on what the dentist(s) believe is in the best interest of the patient. This treatment is **not** based on insurance coverage, and I understand that failure of an insurer to pay for a procedure does not relieve me of the financial obligation for this treatment. *(More than one child may be listed)*

Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____

LIMITATIONS: *Identify any limitation (i.e. root canal, extraction, crown, etc.) on the kinds of dental services for which this authorization is given (if none, please state "none"):*

_____

_____

Parental contact information for questions regarding treatment:

Father's Name: _____ Mother's Name: _____
Daytime Phone: _____ Daytime Phone: _____
Cell Phone: _____ Cell Phone: _____

I hereby indemnify and hold harmless Riccobene Associates Family Dentistry from any and all liability for acting in reliance on this authorization. The individual appointed as proxy is permitted to make decisions or consent to the care in my absence. I agree to accept financial responsibility for all care delivered pursuant to this authorization.

_____ _____
Signature of Parent or Legal Guardian Date