



Authorization for Dental Care on a Minor

I authorize dental treatment to be rendered on my child/minor, _____, without my physical presence in the dental office. I have been advised that it is ideal to have a parent/legal guardian present in the office during treatment in case of any complications or medical situations that may arise.

With knowledge of this, I authorize the OLDE ORCHARD PEDIATRIC DENTISTRY team to take any emergency care/action or precautions deemed necessary. I still retain the authority to approve or decline treatment to be rendered and will make that designation clear before the appointment either in person or by phone consent.

Patient Name

Signature of Parent/Guardian

Signature of Doctor

Date



43025 W. 12 Mile R
Novi, MI 48377
Phone : 248-478-3232
FAX: 248-415-0773

8159 Challis Road
Brighton MI, 48116
Phone: 248.329.0357
Fax: 248.509.0865



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