

Parent or Legal Guardian's Consent for Treatment

Patient: _____ **Chart No.** _____

As parent or legal guardian of the patient named above, I hereby grant permission to the staff of Cincinnati Dental Services to provide dental care for him/her. This consent extends to the care deemed necessary by the doctor(s) to treat the conditions present. This consent includes but is not exclusive to routine preventive and restorative procedures. I also extend my consent to treatment provided when the patient is unaccompanied or accompanied by someone other than me.

I understand that treatment is recommended and rendered based on what the doctor(s) believes 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. I further understand that no guarantees or promises regarding treatment outcome are made by Cincinnati Dental Services.

Unless I provide written notification to the contrary, this consent will remain in effect as long as the patient is a minor or as long as I am his/her legal guardian.

Signature of parent or legal guardian

Date

Signature of Doctor

Date