

Healthy Teeth, Healthy Child

AUTHORIZATION TO TREAT MINOR PATIENT IN THE ABSENCE OF PARENT/GUARDIAN & RELEASE OF ANY PATIENT INFORMATION. _______, the Parent/Legal Guardian of: DOB DOB DOB DOB DOB DOB Hereby Authorize: The release of any dental information pertaining to my child(ren) Relationship to patient ___ Phone Number_____ (Name of person bringing child to office) Relationship to patient ___ Phone Number_____ (Name of person bringing child to office) To accompany my above named child(ren) to the office visits with the Doctor and hygienists of Golnick Pediatric Dentistry and to consent to examination and/or treatment of my children during office visits. This authorization includes the administration of medications as well as the consent to deliver restorative, preventative, and/or any other treatment deemed necessary. I also permit financial issues regarding deductibles, copayments, and insurance information to be communicated and updated. I am ultimately responsible for any and all services rendered. All my questions regarding treatment options were discussed and answered. Additionally, the person accompanying my child will be 18 years of age and provide accurate and updated medical history information including medications, surgeries, heart conditions and current allergies. I am aware I maybe be called if treatment changes, or emergency occurs and will be available to be contact by telephone. This agreement is valld until my child is 18 years old or graduated from out office. I reserve the right to revoke the authorization at any time in writing to Golnick pediatric Dental. ____(Signature) Parent/Guardian Emergency contact phone number ______

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