Amy F. Temple
Family Dentistry D.D.S., P.A.

Minor Patient WITHOUT Parent/Legal Guardian Consent Form

Patient Neme:_____

Patient Date of Birth:_____

AUTHORIZATION

I authorize Amy F. Temples, DDS PA and/or her staff to deliver routine dental treatment and services to my child in my absence. Routine dental care may include, but is not limited to, dental examinations, prophylaxis (cleaning), fluoride treatment, x rays and any other preventative treatment.

PLEASE NOTE that if there are any medical changes, the parent or legal guardian MUST speak directly with the dental health provider.

I understand and agree that the signature and dates on this form will not expire without written notice or when my minor become the age of 18 and that a photocopy/fax copy of this form is considered valid as the original.

Parent/Legal Guardian Signature:_____

Print Name:_____

Relationship to Patient:_____

Date:_____

PARENTAL/LEGAL GUARDIAN CONTACT INFORMTION FOR ANY QUESTIONS

Parent/Legal Guardain's name_____

Contact #'s: (cell) _____ (home) _____ (work) _____

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