General Dentistry
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Child Care Authorization

I, ____, the parent/guardian of the below named minor(s), grant temporary authority to ____________________________, limited to the below defined powers, over the following children:

____   ____

____   ____

The power granted are limited to the following (Please Initial):

_____To discuss with the doctor and office staff protected health information
_____To schedule routine hygiene appointments and operative appointments with nitrous oxide
_____To discuss operative treatment and review nitrous oxide when indicated
_____To sign informed consent forms for treatment
_____To supervise routine hygiene appointments and operative appointments with nitrous oxide
_____To authorize diagnostic x-rays when indicated
_____To authorize fluoride treatment when indicated
_____To review post-operative instructions and care for the child post operatively

Parent/legal guardian must be available by phone at the time of treatment. If parent/legal guardian is not available by phone, the doctor may complete partial or no treatment or will act in the best interest of the child.
Best available Phone # (________)____________________________________

This grant of authority is effective as of_________________ and shall remain in effect until terminated by the undersigned parent/guardian.

This grant of authority is signed this ______________day of _________ in the County of ___________, in the state of New York.

Signature of Parent/guardian:

____

Schoharie Dental, PLLC