Sharonville Family Dental
11440 Lippelman Rd., Cincinnati, OH 45246
Phone (513)-771-9190
Fax (513)-771-6208

TREATMENT WITHOUT PARENT/GUARDIAN CONSENT FORM

I, _____, give Sharonville Family Dental and its affiliates,
Parent/Guardian name

permission to treat my child, _____, while I am not present.
Child's name

The individual bringing my child to the appointment is named, _____ and is at
Adult accompanying child

least eighteen years of age and is the patient's _____. I also give this
Relationship to child

individual permission to make decisions regarding my child's dental treatment, medical treatment (if necessary should an emergency arise) and behavior management. I understand payment is expected at the time of treatment.

Parental **contact information for questions regarding treatment of the child:**

Parent's Name: _____

Contact Info: (Cell) _____ (Home) _____ (Work) _____

Mailing Address: _____

City _____ State _____ Zip Code _____

Signed:_____ Date: _____ Relationship: _____

Individual **given permission to make decisions on the child's dental treatment on my behalf:**

Full Name: _____

Contact Info: (Cell) _____ (Home) _____ (Work) _____

Mailing Address: _____

City _____ State _____ Zip Code _____

Date of Birth_____ Driver's License / ID # _____

Signed:_____ Date: _____