RICHARDSON DMD, INC.
412 E PIONEER AVE, STE 2
HOMER, AK 99603
907-226-2218

CONSENT TO TREAT MINOR WITHOUT PARENT/GUARDIAN PRESENT

Patient Name: _____ **Date of Birth:** ___/___/_____

By signing below, I, _____ am authorizing the dentist, hygienist and staff at the general practice Richardson DMD to examine my child and provide treatment for my child. I realize this form will stay in effect for 6 months unless I provide a written request to discontinue my authorization.

I understand that dental treatments may include but not be limited to:

- **Dental Exams**
- **X-Rays**
- **Hygiene Cleanings**
- **Fillings**
- **Sealants**
- **Fluoride**

Further, I have provided Richardson DMD with an accurate health history for my child. I additionally will ensure that other guardians of my child are aware my child is receiving dental care and I will make my best effort to contact the dentist office regarding my child's future treatment plan and dental needs.

_____ _____
(Printed Name of Parent/Legal Guardian) *(Relationship to Patient)*

_____ ____/____/_____
(Signature of Parent/Legal Guardian) *(Date)*

Parent/Legal Guardian Name and Phone Number:_____

Additional Contact Name and Phone Number:_____

Emergency Contact Name and Phone Number _____

Office Use Only:

_____ _____ ____/____/_____
Witness (please print) *(Signature)* *(Date)*