hersch
PEDIATRIC DENTISTRY AND ORTHODONTICS

400 Newport Center Dr., Ste. 701
Newport Beach, CA 92660
P 949.644.0611 F 949.644.1334

Geoffrey M. Hersch, D.D.S., APC | Pediatric Dentistry
Leslie Butler, D.D.S., Inc. | Pediatric Dentistry
William H. Harrison, D.D.S. | Orthodontics

DENTAL/MEDICAL TREATMENT AUTHORIZATION AND CONSENT FORM

The following form is designed for those situations where minors are unaccompanied by either parents or legal guardians. This "Dental/Medical Treatment Authorization and Consent Form" gives authority to a designated adult to arrange for medical/dental care for a minor in the event of an emergency or when the parent/guardian designates for routine care. This is extremely important, in that, dental/ medical care can not be provided to a minor without approval by the parents or legal guardians, unless there is written consent authorizing an agent to give approval.

I, _____, do hereby confer upon
(Name of Parent or Legal Guardian or Custodian)

_____, residing
at_____
(Name of Person Bringing Child(ren) for Care)

the power to consent to necessary dental/medical for the following child(ren):

1) Name:_____ DOB:_____
2) Name:_____ DOB:_____
3) Name:_____ DOB:_____

and on the child(ren)'s behalf do hereby state that the power to consent that I confer shall not be affected by my subsequent disability or incapacity.

The power that I confer is specifically limited to dental/health care decision-making, and it may be exercised only by the person named above.

The undersigned do hereby authorize Hersch Pediatric Dentistry & Orthodontics or such substitute as he/she may designate as agent for the Undersigned to consent to any X Ray, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care for the above named minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and/or surgeon, licensed under the Provision of Medicine Practice Act or of any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, or elsewhere. The undersigned may also agree to any financial obligations on behalf of the parent/legal
guardian.

Parent or Guardian Signature_____ Date _____
Address of Parent/Guardian _____
Home and Work Phones of Parent/Guardian_____
Witness _____
Family Physician _____
Family Physician's Full Address and Phone Number_____
_____