

# BERT C. VASUT, D.D.S.

## Consent to Treat Patient – Without Parent/ Legal Guardian Present

### AUTHORIZATION:

I have the legal right to preauthorize the office of Dr. Bert Vasut his personnel to deliver routine dental treatment and services to my child. Routine Dental care and interventions may include, but are not limited to: dental evaluation, exam, dental x-rays, cleaning of teeth and orthodontic services.

I \_\_\_\_\_ request and authorize the office of Dr. Bert Vasut personnel to deliver routine dental care to my child listed below as may be deemed necessary or advisable in the diagnosis and treatment of the minor child:

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Current Medications: \_\_\_\_\_  
Chronic Conditions: \_\_\_\_\_

### LIMITATIONS:

Identify any specific limitations on the kinds of dental services for which this authorization is given. (If none, state "none.")

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

Parent's Name: \_\_\_\_\_  
Contact Info: (Cell) \_\_\_\_\_ (Home) \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to bring his/ herself to appointments if I am unable to attend. I understand that dental advice will be relayed to them on my behalf. I understand and agree that the signatures and dates on this form will not expire without written notice or in case that a minor becomes the age of 18 and that a photocopy of this form is considered valid as the original.

\_\_\_\_\_  
Parent or Legal Guardian (Please Print)

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Parent or Legal Guardian (Signature)