Power of Consent Form
Children's Dental Centre of York

I, _____, parent or guardian of

_____, (DOB: ___/___/___)
_____, (DOB: ___/___/___)
_____, (DOB: ___/___/___)
_____, (DOB: ___/___/___)

I authorize the following individuals to perform stated tasks in my absence.
(must be of age 18 years or old)

Name	relationship to patient
Name	relationship to patient
Name	relationship to patient
Name	relationship to patient

Tasks included in absence of authorized individual would be:

- schedule, reschedule, and/or confirm appointments by any means of communication (phone, e-mail, in person, etc…)
- escort patient(s) to appointments
- consent to treatment deemed medically necessary by dentist in our private practice at time of service (treatment to include x-rays, exams, cleanings, fluoride, extractions, crowns, spacers, sealants, pulpotomies, local anesthesia, nitrous oxide/oxygen sedation, etc…)
- review all treatment performed and needed

I am aware that any payment due at time of service will need to be paid either by the person escorting the patient or paid in advance via telephone by myself. I am aware that I can complete and or amend a new Power of Consent form anytime I wish to make changes.

Signature of parent or guardian relationship to patient(s) Date