Angela S. Lutz, D.M.D.
David F. Laughlin, D.D.S.
Diplomates of the American Board of Pediatric Dentistry

Robert W. Bowser, D.M.D.

Please complete all necessary form(s)

Fax back to us @ 717-741-9366

or

email back to us @ appts@childrensdentalcentre.com

(If you have any questions, please contact us @
717-741-0848 during business hours
Mon – Thurs 7:45 am – 4:30 pm)

1399 South Queen Street, Suite A · York, PA 17403 · (717) 741-0848 · www.childrensdentalcentre.com

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…)

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