



PEDIATRIC DENTISTRY

CHILD CARE AUTHORIZATION

713 PIERCE ROAD
CLIFTON PARK, NY 12065
(518) 373-1181 FAX: (518) 373-0130
WWW.SMILELODGE.COM

I, _____, the parent or legal guardian of the below named minors:

am legally entitled to give this authorization and grant temporary authority to the below named individuals:

The authorization granted is limited to the following (check all that apply):

- To discuss protected health information with the doctor and office staff
- To supervise routine hygiene appointments and operative appointments with nitrous oxide
- To authorize diagnostic x-rays when doctor recommended
- To authorize fluoride treatments when doctor recommended
- To discuss operative treatment with nitrous oxide
- To sign informed consent forms for treatment
- To review post-operative instructions
- To schedule routine hygiene and operative appointments with nitrous oxide

Parent/legal guardian must be available by phone at the time of treatment. If Parent/legal guardian is not available by phone, the doctor may complete partial or no treatment or will act in the best interest of the child.

Best available phone #- (_____) _____

This grant of authority is effective as of _____ and shall remain in effect until terminated by the undersigned parent or legal guardian.

Signed, _____ on _____ in the County of Saratoga, NY
(Parent/Legal Guardian) (today's date)