



Caregiver Consent Form

I hereby voluntarily give my consent to the caregiver and authorize him or her to care for my dependent(s), for the period stated in order to arrange for routine or emergency dental care and treatment. I acknowledge that I am the responsible party for all the charges related to dental care and treatment during the time period stated.

The purpose of this consent is to give the caregiver the power and authority to handle my dependent(s) dental care and treatment. This consent will remain in effect until the end of the time period or it is revoked. Any question, concern, or problem regarding this authorization can be directed to me by phone or email that are stated under the "Contact Details" section of this consent form.

Parent/Legal Guardian Name: _____

Dependent(s) Information (please list all children): _____

Caregiver(s) Name: _____

I do not authorize and give my consent to the caregiver on the following:

This authorization is effective between these dates: _____

Parent/Legal Guardian Contact Information:

Phone Number: _____

Email: _____

I hereby sign this consent and acknowledge that I give my consent freely and knowingly.

Parent/Legal Guardian Signature _____ Date _____



PEDIATRIC DENTISTS	ORTHODONTISTS
DR. MIKE LATEINER, D.M.D.	DR. KEVIN G. LEHNES, D.M.D.
DR. PETER PARADISO, D.M.D.	DR. BLAIR SITTMANN, D.M.D.
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