nova Children's Dentistry of ASHBURN

"smiles for a lifetime"

AUTHORIZATION FOR TREATMENT BY NON-GUARDIAN ACCOMPANYING CHILD

I authorize _____ to accompany my child,
(Name and Relation of Person Accompanying Child)

_____, to his/her dental appointment. I agree to the following treatment
(Name of Child)

to be performed in my absence:

- ❑ Examination
- ❑ Radiographs (x-rays) deemed necessary
- ❑ Cleaning
- ❑ Fluoride
- ❑ Necessary restoration of decayed teeth
- ❑ Extractions
- ❑ Emergency treatment as necessary

- ❑ I request that I be contacted at the phone number listed below if treatment needs or recommendations change during treatment.

- ❑ If treatment recommendations change during treatment and I am not able to be reached, I authorize the person accompanying my child to make an informed decision regarding the recommended treatment.

Phone Number: ( ) _____

Parent/Legal Guardian Name: _____

Signature: _____ Date: _____

44121 Harry Byrd Highway, Suite 265, Ashburn, VA 20147
Phone 703-858-1550 • www.novachildrensdentistry.com