Designation of Another to Consent for Medical Care

**Only a patient (18+), parent or legal guardian can fill out this form
**If you have multiple children, a separate form is required for each child

Patient Name:	_____	DOB: __/__/___			
Legal Guardian:	_____	DOB: __/__/___	Relationship to patient:	_____	Phone #:_____
Legal Guardian:	_____	DOB: __/__/___	Relationship to patient:	_____	Phone #:_____

It is recommended that children are brought for care by a parent or legal guardian. To be HIPAA compliant, if you would like to have other individuals bring in the patient above, or allow the practice to discuss your care with another individual, we must have written authorization.

I authorize the following person(s), over 18 years old, to escort the patient above and make decisions including, but not limited to: *(use the check boxes below to designate what appointment types are authorized)*

Dental: Examination, radiographs, prophylaxis (dental cleanings), periodontal treatment & fluoride treatment, consent to use of nitrous oxide analgesia (laughing gas), extractions and restorative appointments (including but not limited to fillings, stainless steel crowns and pulpotomies)
**General Anesthesia, IV Sedation and Oral Sedation appointments are excluded regardless of procedures completed and require a parent/guardian to be present or when applicable parent/guardian consent.*

Vision: Preliminary testing, pupil dilation, exam, choosing eyeglasses, and allow pick up of glasses and/or contact lenses.

Ortho: Radiographs, appliance checks, treatment compliance and retainer checks.
**Initial visits, changes in treatment plan, appointments where braces are being put on or taken off, appointments where contractual changes are being made, informed consent is being updated and as requested by the provider are excluded and require parent/guardian to be present or when applicable parent/guardian consent.*

☐ NO DESIGNATIONS EXCEPT TO THE LEGAL GUARDIAN(S)

OR

Name:	_____	Relationship to patient:	_____	☐ Dental	☐ Vision	☐ Ortho
Name:	_____	Relationship to patient:	_____	☐ Dental	☐ Vision	☐ Ortho
Name:	_____	Relationship to patient:	_____	☐ Dental	☐ Vision	☐ Ortho

☐ The patient is 16 or older, and is allowed to pick up glasses, contacts, and/or orthodontic appliances.

Legal Guardian Name: _____ Signature: _____ Date: _____/_____/_____

Office use only:

- ☐ *Verified accuracy*
- ☐ *Data entered into patient chart*
- ☐ *Form scanned into patient chart*