CHARLESTON PEDIATRIC DENTISTRY
INFANTS | CHILDREN | YOUNG ADULTS

1573 Washington Street East
Charleston, West Virginia 25311
info@cpdwv.com
304.344.0788

PARENT/GUARDIAN VERIFICATION/CONSENT

I, as the parent/guardian of _____, my minor child, voluntarily delegate my legal authority to **Charleston Pediatric Dentistry (Ashley Patnoe, DDS, PLLC), 1573 Washington Street East, Charleston, WV 25311, Phone (304) 344-0788.**

This consent is to be exercised in good faith and in my child's best interest as it applies to:

1. Emergency care;
2. Basic dental care (exams, routine annual x-rays, routine fluoride treatment, cleanings and oral hygiene instruction); and,
3. Restorative care (white fillings, pulpotomy(ies), stainless steel crowns and extractions).

I understand that I will be informed of these services prior to the appointment.

This consent is to be effective from _____ through _____ for the period of time I will not be reasonably available to make such decisions for my child.

I do authorize the following named adult(s) authority to make dental care decisions for the above-mentioned minor in my absence:

_____

_____

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____

Today's Date _____

Current Address _____

_____

Telephone or cell phone number to be reached in case of emergency: _____

****** Please inform this office of any changes which need to be made to this document by the parent/guardian. ******