

**CONSENT TO PROVIDE PREVENTIVE SERVICES TO A
MINOR CHILD IN THE ABSENCE OF THEIR PARENT
OR LEGAL GUARDIAN**

I, _____, as the parent / legal guardian of
_____, do hereby authorize the doctor and staff of Todd A.
Brower, D.D.S., P.L.L.C. to provide preventive dental services to my child / dependent in
my absence.

**By providing this authorization, I assume complete responsibility for notifying the
doctor and staff, prior to treatment, of any changes in my child's / dependent's
medical history.**

This authorization includes permission to provide the following services. Please check
all that apply:

_____ Oral Examination

_____ Diagnostic X-Rays, which may include:

_____ Bitewings – for caries detection

_____ Panorex – for evaluation of teeth and bone development and
abnormalities

_____ Periapicals – to evaluate problems with a particular tooth

_____ Cleaning

_____ Fluoride Treatment

_____ Sealants

I understand that all services may not be covered by my insurance plan, and that I will be
responsible for payment in full of all services rendered.

This authorization will remain in force, until such time as I personally notify the doctor or
clinical staff of any changes.

Signature: _____

Date: _____