Pediatric Dentistry
OF ROUND ROCK
Sage Thames, DDS

Consent to Treat Patient – Without Parent/Legal Guardian Present

I have the legal right to authorize the office of Dr. Sage Thames and his staff to deliver dental treatment and services (routine or otherwise) to my child/children. Routine dental care and treatment may include, but is not limited to: dental evaluation/exam, dental x-rays, cleaning of teeth, fluoride application and restorative dental treatment, as needed or previously discussed with me. Furthermore, I authorize Dr. Sage Thames and/or his staff to take any necessary, lifesaving, medical measures on behalf of my minor child in my absence.

I, ____, the parent/guardian, give Dr. Sage Thames and his staff members authorization, as listed above, to treat my child/children, (list their names) ____, on the following date(s)______________________, in my absence. Additionally, if the circumstance presents itself, I authorize my child/children, (list their names) _________________________________, to bring him/herself/themselves to their dental appointment, and give Dr. Sage Thames and his staff members authorization to release them at the end of their dental appointment.

I have read and understand what is written above, and voluntarily consent to this authorization.

____ ____________________

Parent/Guardian Signature Date

PLEASE EMAIL BACK TO US: info@pdroundrock.com