Joy John, DMD
Kierstin Kerr, DMD
Amanda Peer, DMD
Lauren Murphy, DMD

CONSENT FORM FOR TREATMENT *WITHOUT* THE PRESENCE OF A LEGAL GUARDIAN:

This form is to be completed should a child under the age of 18 come by themselves or with another caregiver.

Date:_______________

I,___________________________, parent of ____

give consent for him/her to have the following procedure(s) done in my absence and give Duxbury Children's Dentistry permission to discuss possible treatment, dental findings, and/or account balances prior to the visit with ____(name of caregiver or teenaged child).

Please list (2) phone numbers at which we can contact a parent/legal guardian during appointments:

Name & Number:_____________________________ ***Name & Number***:_______________________

Medical Concern or Changes: ____

I am aware of the treatment plan and agree to allow my child to have the following done in my absence:

- Dental Cleanings, X-rays, Exams, Sealants, Fillings and Emergency Visits. _______**Initial**

If I wish to change my consent to any of the above listed procedures I am aware that it is my responsibility to call and speak directly to the office prior to my child arriving for each appointment.

****It is your responsibility to call the office for each appointment to update your child's medical history and to provide additional consent for procedures other than a cleaning and x-rays.**

The following procedures require same day written consent:

Nitrous Oxide (laughing gas), Extractions and Silver Diamine Fluoride: ** See below regarding a consent form**

We highly recommend that parents be present at extraction or nitrous oxide appointments. If you are unable to attend these appointments please go to our website, **www.duxburychildrensdentistry.com**, to print and complete the corresponding consent forms (Extraction or Nitrous Oxide or Silver Diamine Fluoride) and send them along with your caregiver or fax to (781) 934-7125.

I give permission for these dentists (Dr.Joy John, Dr.Kierstin Kerr, Dr.Amanda Peer and Dr.Lauren Murphy) to make minor changes to the treatment plan should it be necessary for the health or well-being of the child if we cannot get in touch with you at the phone numbers provided above: (**Yes / No**)

Please note: We will make an effort to contact you at one of the provided numbers above if an unexpected change occurs. If we cannot reach you we may need to book additional appointments for your child to complete the work.

Co-Pays & fees are due at the time of service. Please call our office to arrange payment prior to the visit.

This consent remains in effect until revoked in writing.
By signing below, I confirm that I have read, understand and agree to the above.

Parent/Legal Guardian Name:____

Parent/Legal Guardian Signature: ___________________________________ **Date**: ____________