BARTH FAMILY DENTISTRY, PSC
Dr. Charity A. Barth
NPI# 198-270-4656
1821 Florence Pike, St. #2, Burlington, KY 41005
Phone: (859) 689-7700, Fax: 859-689-9641

Permission For Dental Examination and/or Treatment of a Minor

I, _____ (Print Parent/ Guardian's full name), am the parent or legal guardian of_____ (print full name of child) who is a minor and hereby, authorize and consent to the examination and any/ all treatment as deemed necessary by or under the supervision of Dr. Charity A. Barth/ Barth Family Dentistry. This includes examinations, exposure of radiographs as necessary, use of local anesthetic, sedatives, reasonable restraints as needed for the child's safety, and use of appropriate medications, medicaments and materials for any such dental treatment, under general, direct or indirect supervision of Dr. Charity A. Barth, her staff members, or agents.

I accept full financial responsibility with or without insurance coverage or insurance denial of coverage for any/all known and unknown diagnostics and treatment procedures performed by Barth Family Dentistry.

This consent is intended for unforeseen emergency purposes and for routine dental care.

A complete medical history, billing and financial policy form, consent to treat form and HIPPA form must be completed for the minor by parent or legal guardian prior to signing this consent form.

This authorization will remain in effect until canceled in writing by me or the child turns the legal age of 18 (eighteen).

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THE INFORMATION GIVEN ME VERBALLY. BY MY SIGNATURE BELOW, I CONSENT TO THE TREATMENT DESCRIBED IN THIS DOCUMENT.

_____

Parent or Legal Guardian Signature Date

_____

Witness Signature Date