Barto Pediatric Dentistry

Practice Limited to Pediatric & Adolescent Dentistry

I, ____________________________, being the parent/legal guardian of said child, or children give Dr. David E. Barto, Jr., and his staff permission to perform the following dental preventive, restorative, and any other treatment deemed necessary:

(Please initial each of the following blanks below if you are in agreement)

> **______Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.**

- **______Treatment: Preventative and Restorative**
- **______Diagnostic x-rays and/or diagnostic impressions**
- **______Administer Nitrous Oxide and Oxygen**
- **______Administer Conscious Sedation**
- **______Mail statements, reminder cards or birthday cards, file insurance, and any collection procedures necessary on my account**
- **______Call, text, or email for confirmation of scheduled appointments, appliance information or prescription information related to or about the patient**
- **______Take photograph of patient for office identification use only(non-commercialized)**
- **The procedures to be performed have been fully and clearly explained to me, and I understand the benefits and risks involved. I have been able to ask any questions concerning these procedures and they have been answered to my satisfaction. This authorization remains valid and effective from the date of signing until revoked in writing.**

____

Child's Name

____________________________________ **Relationship:**__________________________

Signature of Legal Guardian

Date: ______________________________

PERMISSION FORM

I ____________________________ give my permission for

1. ______________________________________,

Relationship: ___________________________,

2. ______________________________________,

Relationship: ___________________________,

3. ______________________________________,

Relationship: ___________________________.

To bring my child _______________________ to Barto Pediatric Dentistry and make treatment decisions as well as receive any necessary information regarding treatment/ procedures.

____

Child's Name

____

Signature of Legal Guardian & Relationship **Date**