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, <u>prior to treatment</u>, 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: _____