NORWOOD PEDIATRIC DENTISTRY
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www.NorwoodPediatricDentistry.com

WAIVER TO TREAT MINOR CHILD WITH AUTHORIZED REPRESENTATIVE

I, (print name) _____, authorize the following persons who are over the age of 18 to accompany my child, (print name) _____to their dental appointment(s)**. (NOTE: This waiver only applies to appointments in the Norwood Pediatric Dentistry)** Each of these persons is authorized by me to consent to dental treatment for my child and I agree to be financially responsible for the treatment decisions made by them. I understand that proper identification will be required. I understand that if my child's account is past due, the appointment may be rescheduled.

1) Authorized Person: _____

2) Authorized Person: _____

3) Authorized Person: _____

I understand that if a medical emergency arises, my child may be at risk. I authorize Norwood Pediatric Dentistry to make medical decisions in my absence. I release Norwood Pediatric Dentistry of any responsibility and/or liability that may occur during my child's dental appointments if I am not present and did not send a legal representative over the age of 18.

I understand that my child's planned dental treatment may change. I authorize Norwood Pediatric Dentistry to change the planned dental treatment in my absence and I agree to be financially responsible for any treatment that is not covered by dental insurance.

In the event I wish to remove one of the persons noted above, I will complete a new waiver, sign and date it and submit it to the staff in the Norwood Pediatric Dentistry.

Parent/Guardian Name: _____ Date: _____