Shores Family Dentistry

Dr. John Siegmund & Dr. Jon Anderson
& Dr. Joy Troxel
4360 Boardwalk Dr. Suite 100
Fort Collins, Co. 80526
970-226-2920

Consent to Treat Patient-without Parent/Legal Guardian present

AUTHORIZATION:

I have the legal right to preauthorize the office of Dr. John Siegmund / Dr. Jon Anderson and their personnel to deliver routine dental treatment and services to my child. Routine Dental care and interventions may include, but are not limited to: dental evaluation, exam, dental x-rays, fluoride cleaning of teeth and orthodontic services.

I ______________________________ request and authorize the office of Dr. John Siegmund /Dr. Jon Anderson and their personnel to deliver routine dental care to my child listed below as may be deemed necessary or advisable in the diagnosis and treatment of the minor child:

Child's Name: ___________________________________ DOB: ____________________
Allergies: ____
Current Medications: ____
Chronic Conditions:____

LIMITATIONS: Identify any specific limitations on the kinds of dental services for which this authorization is given. (If none, state "none.") Parental contact information for questions regarding treatment of the child:
Parent's Name: ____
Contact Info: (Cell) _______________________ (Home) ______________________
Mailing Address: ____
City _________________ State __________ Zip Code _____________

I hereby authorize __________________________________ to bring his/ herself to appointments if I am unable to attend. I understand that dental advice will be relayed to them on my behalf. I understand and agree that the signatures and dates on this form will not expire without written notice or in case that a minor becomes the age of 18 and that a photocopy of this form is considered valid as the original.

Parent/Guardian Signature____Date____________