

GUARDIAN ACCOMPAINMENT FORM

Please email to: office@mightychildrensdentistry.com or fax to: 954.688.3414 **PRIOR** to your child's next appointment.

I, _____, will be unable to accompany my child to his/her upcoming dental appointment. I authorize Mighty Children's Dentistry to treat him/her as needed and take x-rays as deemed necessary for my child's dental treatment. I further authorize Miami Children's Dentistry to provide any medically necessary emergency treatment.

PATIENT NAME: _____ DOB: _____

DATE OF APPOINTMENT: _____

NAME OF PERSON ACCOMPANYING PATIENT: _____

RELATIONSHIP TO PATIENT: _____

In case of Emergency during this visit,

PARENT'S CONTACT PHONE NUMBER AT TIME OF APPOINTMENT: _____

MEDICAL HISTORY
(Please check all that apply)

_____ There are NO CHANGES in my child's medical history since his/her last visit.

_____ There are the following changes in my child's medical history since his/her last visit:

_____ My child is currently taking NO MEDICATIONS.

_____ My child is currently taking the following medications:

_____ Permission for Fluoride treatment

_____ Permission for X-Rays

_____ Permission to discuss treatment with person accompanying child

_____ Permission for Nitrous if needed

Signature of Parent or Legal Guardian

Date

OFFICE USE ONLY

Received Date: _____ Entered in OD Date: _____ By: _____

Team Member