Patient Name: _____

Date of Birth: _____

Practice location: _____

Northland Smiles

CONSENT FOR TREATMENT SPECIAL HEALTH CARE NEEDS

To facilitate dental care and treatment of , _____, (diagnosed with Special Health Care Needs), by Northland Smiles, the undersigned parent or legal guardian of the Patient hereby agrees as follows:

1. **Direct Authorization for Treatment by Northland Smiles**. A dental examination has been completed at Northland Smiles and a treatment plan has been given to me for the above named patient. All risks/benefits and alternatives to treatment have been explained to me. I have been given an opportunity to ask all questions and they have been adequately answered. I verify that I have legal authority to grant consent for the treatment of the above named patient. I authorize Northland Smiles to provide the Patient with the following treatment:

Tooth cleaning	Extraction of "baby" teeth
Sealants	Extraction of permanent teeth
Fillings	Root Canal Treatment
Fluoride	Other _____

(This allows a patient to come to an appointment(s) unaccompanied by parent/guardian/parent substitute.)

2. **Identification of Parent/Guardian Substitute**. I appoint the following Parent/Guardian Substitute(s) to obtain access to Protected Health Information or give informed consent for care and treatment.

Name	**Relationship to Patient**	**Phone Number**
_____	_____	_____

4. **Duration.** This authorization is valid for the specific treatment plan explained and agreed to on _____ (date). This authorization will be voided if significant changes occur in the treatment plan, if patient fails appointments or if oral conditions have changed and another dental examination is required within a 6 month period of time.

I have carefully read and considered this consent form before signing it.
SIGNATURE OF PARENT OR LEGAL GUARDIAN:

_____ _____

Signature Date

Legal Authority: Parent Legal Guardian

CONTACT INFORMATION CONCERNING PARENT OR LEGAL GUARDIAN:

_____ _____ _____

Name Relationship Contact Phone Number