Gateway Dental
44330 Premier Plaza - Suite 140
Ashburn, VA 20147
Phone: (703)726-0333

ADVANCE CONSENT TO TREAT MINOR CHILD

I, ______________________________, the parent or legal guardian of my child,____________________________________, hereby authorize and consent to the rendition of routine and emergency dental treatment for my child when deemed necessary by licensed dentist(s) and qualified dental personnel of Gateway Dental. This authorization will remain in effect until revoked in writing by me and this authorization shall remain a permanent part of my child's Gateway Dental treatment record.

_______________________________________ ____________________________

Signature of parent/legal guardian Date

IMORTANT PLEASE READ

This document will not be accepted as authorization by Gateway Dental and its licensed dentist(s) and qualified dental personnel prior to the rendition of an initial comprehensive or emergency dental examination and other diagnostic tests and radiographs. The parent or legal guardian must be present at the initial comprehensive or emergency visit. Gateway Dental reserves the right to require the presence of the parent or legal guardian at any or all future dental visits at the election of its licensed dentist(s) and qualified dental personnel.