Treatment Consent of a Minor in the Absence of a Parent/Guardian

I give the doctors and team at Doshi Orthodontics permission to treat my child while I am not present. Orthodontic treatment includes but is not limited to changing of archwires, placement of alastics, powerchains, brackets, using elastics, taking radiographs, completing interproximal reduction, taking impressions, and discussing treatment including oral hygiene, compliance, and treatment progression. In case of medical emergency, I give the doctors and dental team at Doshi Orthodontics permission to administer any medical care required including contacting emergency medical services. I understand treatment of any kind carries inherent risks. I am encouraged to contact the office with any questions about treatment and understand I will be informed of any changes to my child's treatment plan.

Patient Name ________________________________

Parent/Guardian Name _________________________________

Parent/Guardian Signature ______________________ Date _________________