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Monroeville, OH 44847
(419) 465-2574
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PREAUTHORIZATION TO TREAT MINORS WITHOUT A PARENT OR GUARDIAN PRESENT

I give authorization for Monroeville Dental to deliver medical/dental treatment to my child without my presence in the office.

Patient Name: _____ DOB: _____

Guardian Name: _____

Signature: _____ Date: _____

CONSENT BY PROXY FOR TREATMENT OF MINOR BY DELEGATED CAREGIVER

(Right to delegate people to bring your child to visits and make medical decisions)

I give consent to the delegated caregivers listed below as my proxy decision maker for consenting to non-urgent medical care for my child listed below. I have the legal right to delegate such consent to the decision maker who is an adult and legally and medically competent to exercise the authority so delegated. Be advised that protected patient health information may be shared with the proxy who the right to consent has been delegated to facilitate informed decision making.

1. Proxy Name: _____ Relationship to Patient: _____
2. Proxy Name: _____ Relationship to Patient: _____
3. Proxy Name: _____ Relationship to Patient: _____
4. Proxy Name: _____ Relationship to Patient: _____

Patient Name: _____ DOB: _____

Guardian Name: _____

Signature: _____ Date: _____

THIS WILL STAY ON FILE AT MONROEVILLE DENTAL UNTIL YOU REVOKE IN WRITING