David S. Yasuda, DDS

Consent to Provide Services to a Minor Child
In the Absence of Their Parent or Legal Guardian

I, _____, as the parent / legal guardian, of
Print parent / legal guardian's name
_____ do hereby authorize the doctor and team of
Print minor patient's name
David S. Yasuda, DDS to provide dental services to my child / dependent, in my absence.

By providing this authorization, I accept complete responsibility for notifying the doctor and team, *prior to treatment*, of any changes in my child's/dependent's medical history.

This authorization includes permission to provide the following services. Please check all that apply:

- ❑ Oral Examination
- ❑ Diagnostic dental films, which may include:
  - ❑ Bitewings: for cavity detection
  - ❑ Periapicals: to evaluate problems with a particular tooth
  - ❑ Panorex: to evaluate positioning of third molars and anatomic abnormalities
- ❑ Prophylaxis (professional dental cleaning)
- ❑ Fluoride Treatment
- ❑ Sealants
- ❑ Restorative Treatment

I understand that all services may not be covered by my dental benefits, and that I will be responsible for payment in full of all services rendered.

This authorization will remain in force, until such time as I *personally* notify the doctor or team of any changes.

Signature: _____ Date: _____