MIDLOTHIAN CHILDREN'S DENTISTRY

General Consent Form

Today's Date:

Welcome to our practice! We want to make things easier for you. Let us communicate on your behalf.

Patient Name _____ **Birthdate:** _____

Patient Name _____ **Birthdate:** _____

Patient Name _____ **Birthdate:** _____

Patient Name _____ **Birthdate:** _____

Permission to Communicate with Child's Physicians

I, _____ give my permission to Midlothian Children's Dentistry to send update letters about my child, _____'s dental care and conditions to his or her primary care physician to keep in compliance with a patient centered medical-dental home. Our goal is to keep your child happy and healthy.

_____

Primary Care Physician/ Pediatrician **Office Contact Telephone Number**

Permission to Allow Friends and Family to Accompany Child and Consent for Dental Care

By signing below, I give permission to the person(s) listed in the table documented to accompany the child/ren listed above to his/her dental appointments and to act on my behalf to give consent for any dental or diagnostic treatment. I also give permission for the following individuals to receive Private Health Information about my child/ren regarding treatment, dental conditions, and health history as it pertains to the dental visit. I further understand that whoever should bring my child/ren to his/her appointment will be responsible for payment at the time services are rendered. I understand this form is legally binding and that I may revoke my authorization at any time by submitting in writing to change, add, or terminate.

Date	Family/Friend Name	Relationship to Patient	Guardian Initials	Phone#

Permission of INFORMED CONSENT for Photography:

☐ I DO ☐ I do NOT give permission to Dr. Patel and the staff at Midlothian Children's Dentistry to take and use photographs of my child/ren on educational purposes, which may include submissions in publication(s), website(s), brochure(s), and other social media.

Office Policy Regarding Scheduled Appointments:

- **If you are 10 minutes or more late for an appointment you may be rescheduled.**
- **If you provide less than 48 hours notice for a cancellation request it will be considered a broken appointment.**
- **At 3 broken appointments, within each calendar year, the patient will be dismissed from the practice.**
- **If a scheduled Sedation or General Anesthesia appointment is cancelled less than 72 hours it will be considered a broken appointment.**
- **Not obtaining the History and Physical (H&P) from your child's pediatrician timely OR patient No Shows the day of a scheduled Sedation or General Anesthesia appointment without a valid medical excuse he/she will be dismissed from the practice.**
- **Dismissal from the practice will be provided as follows: A certified dismissal letter to your home address. You will be provided 30 days of emergency care needs only.**

We genuinely care about you and your family. We maintain this policy to provide each child with the highest quality of care in a timely manner.

Signature of Parent/Legal Guardian: _____ **Date:** _____

Printed Name of Parent/Legal Guardian: _____ **Relationship:** _____