General Consent Form

Smile Garden Pediatric Dentistry is proud to be your family's choice for a dental home.
We are a patient-centered practice with a goal of helping our patients live happy and healthy lives.
We maintain this policy to provide each child with the highest quality of care in a timely manner.

Patient Name ____ Birthdate: ______________________________

Patient Name ____ Birthdate: ______________________________

Patient Name ____ Birthdate: ______________________________

Patient Name ____ Birthdate: ______________________________

Permission to Communicate with Child's Physician

I, ______________________________________, give my permission to Smile Garden Pediatric Dentistry to send information regarding my child's/children's dental care and condition to the primary care physician listed below. I give permission to Smile Garden Pediatric Dentistry to send a copy of radiographs (x-rays) to the primary care physician listed below.

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Primary Care Physician/ Pediatrician **Office 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 below to accompany my child/children to his/her dental appointments, to act on my behalf, and 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/children 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 a request 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 Smile Garden Pediatric Dentistry to take and use photographs of my child/children for educational purposes, which may include submissions in publication(s), website(s), brochure(s), and other social media.

Office Policy Regarding Scheduled Appointments:

- I understand that if I am 10 or more minutes late for an appointment that I may be rescheduled.
- I understand that a cancellation request provided less than 48 hours in advance will be considered a broken appointment.
- I understand that if I have 3 broken appointments I will be dismissed as a patient from the practice.
- I understand that scheduled General Anesthesia appointments must be cancelled/rescheduled 2 weeks in advance.
- I understand that I must obtain a History and Physical (H&P) from my child's pediatrician before a scheduled General Anesthesia appointment.
- I understand that missing a scheduled General Anesthesia appointment without a valid medical excuse will result in dismissal from this practice.
- I understand that if I am dismissed from this practice, I will receive a certified dismissal letter to my home address and that I will receive 30 days of emergency care needs only.

Signature of Parent/Legal Guardian: ________________________________ **Date:** ______________________

Printed Name of Parent/Legal Guardian: ______________________________ **Relationship:** __________________