PARKVIEW DENTAL
ASSOCIATES

SUBSTITUTED CONSENT FOR TREATMENT OF MINORS AND INCOMPETENTS

I, the undersigned parent/guardian of _____, in the event that I cannot be contacted through reasonable efforts, hereby empower and grant to PARKVIEW DENTAL ASSOCIATES, SC permission to consent and authorize dental treatment for my above named minor child/ward. This authorization shall be valid for the period of time commencing on this _____ day of _____, 20_____, and ending on the minor child's 18th birthday.

I do hereby indemnify and hold harmless Parkview Dental Associates, the doctors, hygienists, assistants, and any other persons who act in reliance upon this authorization.

_____

Parent/Guardian Signature

Parent/Guardian can be located at the following address/phone number/email:

_____

_____

Minor child/ward's known allergies:

_____

_____