Unaccompanied Minor Authorization Form

(please complete a separate form for each child)

I, the undersigned, attest that I am the parent or legal guardian of the child named below and authorize Aland Family Dentistry (AFD) to treat my child despite my being present in their office. I understand that all costs associated with this appointment are my responsibility and authorize AFD to pay the balance due via the method I have selected below. I understand that if my child is due for preventive services in addition to a routine cleaning and exam, such as sealants, fluoride, and/or x-rays, AFD will consider my signing this authorization as consent to perform these services, unless I contact them prior to the appointment time to verbally decline.

I agree to hold AFD harmless should an unforeseen change in treatment occur and I am not reachable by the number listed below. I agree to answer or return any calls made by AFD within 5 minutes of their attempt to contact me regarding my child's. care, or they may reserve the right to proceed as they deem reasonably necessary.

Parent/Legal Guardian Signature: ___________________________________

Printed Name: _____________________________ Date: _______________

Child's Full Name: _______________________________ DOB: ___________

During the appointment, I can be reached at: _________________________

Authorized Method of Payment: (please circle)

Cash Check # and amount: ________________________________

Credit Card: _______________________________________ (account number)

______________________________ (account holder's signature)

______________________________ (expiration date MM/YY)

Care Credit: _______________________________________ (account number)

______________________________ (account holder's signature)