AVI WEINER D.M.D., LLC
AVENUE SMILES

7300 City Ave
Philadelphia, PA 19151
Phone: 215-877-0900

PERMISSION TO TREAT A MINOR WITHOUT A PARENT/GUARDIAN PRESENT

Avi Weiner, D.M.D., LLC ~ Avenue Smiles must receive permission from a child's parent or legal guardian before providing dental treatment for any injury or condition that is non-life threatening. This form gives our office the legal permission and consent to treat your child in case you cannot accompany him/her to an appointment. If the party accompanying your child, who must be at least 18 years of age (baby-sitter, relative, friend, etc.) does not present this form, our office will attempt to contact you to request verbal authorization to treat your child. The verbal authorization will be documented in your child's medical records. If we are unable to reach you, services will not be performed and you will need to contact the office to reschedule.

PLEASE NOTE:

- A parent/legal guardian MUST be present for their child's first visit with Avi Weiner D.M.D., LLC ~ Avenue Smiles
- The accompanying party MUST BE greater than 18 years of age
- A new "Permission to Treat a Minor" form is required for **each** visit that a minor will be seen without his/her parent/legal guardian present

PATIENT NAME: _____

PATIENT'S DATE OF BIRTH: _____ **TODAY'S DATE:** _____

I, _____ (Parent/Legal Guardian), grant _____ (Accompanying Party)
(an adult into whose care, the minor has been entrusted) to arrange for and authorize routine and emergency treatment at Avi Weiner, D.M.D., LLC ~ Avenue Smiles. This authorization grants consent to any x-ray, examination, dental diagnosis and treatment.

I, acknowledge that I am responsible for all charges in connection with the care and treatment rendered.
(Please be sure to send the insurance card and co-pay (if applicable) to the appointment.)

IN CASE OF AN EMERGENCY, MY PHONE NUMBERS ARE:

Home: _____ **Work:** _____ **Cell:** _____

During the appointment time, please call me first at _____ (Location) **and if I am not available try me at** _____ (Location).

PARENT/LEGAL GUARDIAN SIGNATURE: _____

PRINTED NAME: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____

CONSENT IS VALID FOR ONE YEAR FROM THE DATE IT IS SIGNED ABOVE