CONSENT FOR TREATMENT OF UNACCOMPANIED MINOR

Name of Minor Child: _____ ("Minor")

Date of Birth of Minor: _____

Name of Parent or Legal Guardian: _____

I acknowledge that I am the parent or guardian entitled to the care, custody, and control of Minor. I hereby request, authorize and direct Lockett Orthodontics to examine and treat Minor in my absence.

This consent and authorization:

- ☐ is effective only on: _____. (month/day/year)
- ☐ is effective from: _____ to _____. (month/day/year)

☐ is effective for 180 days from the date of my signature below.

I understand that, in certain circumstances, the healthcare providers of Lockett Orthodontics may require that a parent or other authorized adult be present with Minor to assist in the diagnosis or treatment process. I agree to cooperate by being present at all times possible and when specifically requested by Lockett Orthodontics.

Signature of Parent or Legal Guardian: _____

Relationship to Patient: _____

Date: _____