Johnson Orthodontics

EXTRAORDINARY SMILES, EXTRAORDINARY SERVICE

MINOR PATIENT CONSENT FOR ORTHODONTIC TREATMENT IN THE ABSENCE OF A PARENT OR LEGAL GUARDIAN

Patient Name: _____

Date of Birth: _____

AUTHORIZATION

I authorize Johnson Orthodontics to perform routine orthodontic procedures and adjustments that are part of my child's established treatment plan when I am not present.

I understand that a summary of my child's orthodontic appointment and any instructions or recommendations will be communicated to me through the practice's customary methods of communication (text or email) and that I am responsible for reviewing the summary and contacting the office with any questions or concerns.

☐ YES, my child may attend orthodontic appointments without a parent/legal guardian present.

☐ NO, my child may not attend orthodontic appointments without a parent/legal guardian present.

Parent/Legal Guardian Signature: _____

Printed Name: _____

Date: _____

This authorization shall remain in effect until revoked in writing by me, until the patient reaches 18 years of age, or until active orthodontic treatment is completed, whichever occurs first.