Unity Care NW

CONSENT TO DENTAL TREATMENT

Patient's Name (Last, First, Middle Initial):_____

Patient's Date of Birth:_____ Record Number (to be filled out by clinic)_____

Name of Parent/Guardian/Responsible Person:_____

I understand and agree to the following procedures (Please initial by each):

_____Screening/Exam

_____ X-rays

_____Fluoride Varnish

_____Prophylaxis (cleaning)

_____Sealants

_____Restorative (fillings)

_____Endodontics (root canal)

_____Oral Surgery (tooth removal)

_____Treatment under nitrous Oxide

I understand that a staff dentist or a representative of Unity Care NW may perform the procedures listed above. I understand that no promises have been made to me about the outcome of any procedures and that complications may arise. I understand that a clinic representative is available to answer my questions or concerns.

I also give my permission to the Unity Care NW and its representatives to make and use x-ray, photographs, and/or videotapes of the person named in this consent as deemed necessary for any diagnostic and/or educational purpose. I have full knowledge that these forms of media may be deemed necessary and proper to the interests of health education, knowledge or research by Unity Care NW and that if used in any publications, I shall not be identified by name.

I listed any known allergies or other problems on the Patient History Form.

I requested the disposal by authorities of Unity Care NW Dental Clinic of any tissue, which may be necessary to remove.

Minors under the age of 12 are required to be accompanied by an adult.

Signature (patient, parent, or guardian) Date

Print Name_____ , Relationship to patient_____