CONSENT TO DENTAL SCREENING

PATIENT NAME: _____

LOCATION: _____ DATE: _____

DIAGNOSIS: _____

RECOMMENDED TREATMENT:

_____

_____

_____

CONSEQUENCES IF NO TREATMENT ADMINISTERED, ARE NOT LIMITED TO THE FOLLOWING:

_____

_____

_____

DR. _____ HAS COMPLETED AN INITIAL SCREENING FOR _____ (PATIENT'S NAME). I UNDERSTAND THAT THE SCREENING IS ONLY A LIMITED MEANS OF DIAGNOSIS AND I MUST SECURE THE SERVICES OF A DENTIST OR DENTAL CLINIC. DR. _____ HAS EXPLAINED TO ME THE POTENTIAL CONSEQUENCES OF NOT PROCEEDING WITH TREATMENT AND GIVEN ME THE OPPORTUNITY TO ASK QUESTIONS REGARDING THE INFORMATION I HAVE BEEN PROVIDED. IF I HAVE ASKED ANY QUESTIONS, I AM ALSO ACKNOWLEDGING THAT THOSE HAVE BEEN ANSWERED TO MY SATISFACTION.

I WILL NOT HOLD DR. _____ RESPONSIBLE, SHOULD I CHOOSE TO NOT SEEK CARE FROM A DENTIST OR CLINIC AS WAS RECOMMENDED.

_____ _____

PATIENT'S OR LEGAL GUARDIAN'S/ REPRESENTATIVE'S SIGNATURE DATE

I HAVE EXPLAINED THE NATURE, PURPOSE, RISKS, COMPLICATIONS, BENEFITS, AND ALTERNATIVES TO THE PROPOSED TREATMENT, AS WELL AS THE RISKS AND CONSEQUENCES OF PROCEEDING WITH THE TREATMENT. I HAVE ANSWERED ALL OF THE PATIENT'S QUESTIONS, AND I BELIEVE THAT THE PATIENT/GUARDIAN/REPRESENTATIVE FULLY UNDERSTANDS MY ANSWERS AND EXPLANATIONS.

_____ _____

DENTIST'S SIGNATURE DATE