Macon County
Public Health

Consent for Dental Examination & Treatment

1. I understand the dental staff will perform an oral examination on myself and provide needed dental care based on the dentists' findings. Dental treatments may include cleanings, preventive therapies, preventive agents, digital radiographs, restorative fillings, extractions and limited replacement options such as resin-based partials or dentures.

2. I understand that emergency treatment may be limited and is done to relieve pain, swelling, infection and injury. I will be required to sign a Release of Records Form if a referral to a specialist is required for continuity of dental care.

3. Sometimes problems can occur. I understand there are risks in dental treatment; which may include pain, soreness, swelling, infection, bleeding, injury to nearby teeth and gums, problems with joints in the mouth or jawbone, numbness and/or allergic reactions.

4. I have been given the opportunity to have all my questions answered and agree to participate in the Adult Dental Program.

5. Failure to comply with the above stated responsibilities reserves MCPH the right to reschedule your visit, refer you to another practice or dismiss you from our clinic.

6. A maximum of 2 family members will be scheduled for dental care in any day. It is the patient's responsibility to adhere to the Appointment Policy and all Policies set forth as stated in detail on Form: Clinic & General Policies (pg. 4 of this packet).

SIGN

_____ _____

Patient's Name | Signature of Patient/Parent/Legal Guardian

SIGN

_____ _____

Relationship (Self, Parent, Guardian) | Date