Serve the People Community Health Center (STP CHC)

Consent form for

Dental Prevention Treatment

Patient's Name:		Date of Birth:	

It is your right, as a patient or parent, to understand the risks, benefits, and alternatives of your dental treatment, and to accept or refuse treatment offered to you. Please read this form carefully and ask about anything you do not understand. We will be pleased to answer your questions.

Dental Exam: Every person is a unique individual thus not every person will require the same treatment to obtain comprehensive oral examination. Based upon your age, teeth present, and tooth position the dentist will determine if radiographs (x-rays) are necessary. The examination appointment also includes the use of instruments to see if the surface of the teeth are fragile and in the process of the exam the surface of the tooth may be found to have decay during the exam. Unless otherwise noted, by signing this form I authorize STP's staff to perform a dental exam.

By checking off the box to the right, I am stating that I refuse a dental exam and I understand the implications in doing so. ☐

Dental Cleaning: Removal of plaque, stain, and materials of the surface of the teeth should be done on a regular basis as determined by a person's risk for dental disease. Unless otherwise noted, by signing this form I authorize the STP's staff to clean my teeth.

By checking off the box to the right, I am stating that I refuse a dental cleaning and I understand the implications in doing so. ☐

X-rays: X-rays are used to diagnose oral diseases and their need is determined by each person's individual situation. Effects of radiation add up over time and we make an effort to minimize the patient's exposure by using the lowest dose of exposure and use of protective collars and aprons. Unless otherwise noted, by signing below I authorize STP's staff to take x-rays.

By checking off the box to the right, I am stating that I refuse to receive x-rays and I understand the implications in doing so. ☐

Fluoride treatment: The AADP has stated that topical fluoride is safe and highly effective in reducing the risk of caries and reversing enamel demineralization. I understand that fluoride treatment will help strengthen the enamel of the surface of my teeth. Unless otherwise noted, by signing this form I authorize to have fluoride applied to the surface of my teeth.

By checking off the box to the right, I am stating that I refuse fluoride treatment and I understand the implications in doing so. ☐

Sealants: Sealants are protective coating that is applied to the grooves of the molars. I authorize STP's staff to apply sealants to my molars.

By checking off the box to the right, I am stating that I refuse sealants and I understand the implications in doing so. ☐

Changes in treatment plan: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. Unless otherwise noted, by signing this form, I give permission to the Dentist to make any changes and additions as necessary, after having been informed, and am in agreement with the changes.

By checking off the box to the right, I am stating that I refuse changes in the dental treatment plan, and I understand the implications in doing so. ☐

I hereby request and authorize the dentists and their STP staff to perform dental work in attempting to improve the appearance, function, and health of mouth, teeth, bone and tissue, as explained above. The effect and nature of the procedures to be performed, and the risks involved as well as the possible alternative methods of treatment have been fully explained to me. I understand that dentistry is not an exact science and that therefore, no practitioner can fully guarantee absolute results. I acknowledge that no guarantee has been made by anyone regarding the dental treatment, which I have authorized. Although our goal is the best oral health for the patient, there are some slight risks involved in getting to that goal. Very rarely dental treatment may be associated with numbness, bleeding, discoloration, soreness, upset stomach, dizziness, allergic reaction, swelling, and infection but ignoring a known dental problem has an even greater risk. Not treating existing dental problems results in abscess, infection, pain, fever, swelling, considerable risk to the developing adult teeth, and may create future orthodontic and gum problems.

By signing below, I confirm that I have read and fully understand the information above and have had all my questions answered to my satisfaction. I consent to the proposed dental treatment.

Printed Name of Patient / Parent/ Tutor / Representative	**If applicable, relationship to patient**
Signature of Patient / Parent/ Tutor / Representative	**Date (MM/DD/YYYY)**