SOUTH COVE COMMUNITY HEALTH CENTER

Patient Consent for Specialized Dental Treatment

Patient Information

Patient Name: _____

Date of Birth: _____

Medical Record Number (if applicable): _____

If patient is under 18 year old:

Parent/Legal Guardian Name: _____

Relationship to Patient: _____

Phone Number: _____

Consent for Specialized Dental Treatment

I (patient or parent/legal guardian) authorize the dentists, dental hygienists, dental assistants, residents, students (when applicable), and other authorized dental personnel at South Cove Community Health Center to provide specialized dental care that is considered necessary.

I understand that dental treatment may include, but is not limited to:

- ☐ Dental fillings (restorations)
- ☐ Tooth extractions
- ☐ Root canals
- ☐ Local anesthesia
- ☐ Pulp therapy (including pulpotomy or pulpectomy when indicated)
- ☐ Stainless steel crowns or other restorative crowns
- ☐ Space maintainers
- ☐ Emergency dental treatment necessary to relieve pain, control infection, or prevent further injury
- ☐ Partial Dentures
- ☐ Complete Dentures

- ☐ Other: _____

Brief Description of Treatment:

_____

_____

I understand that the nature, purpose, benefits, and possible risks of the proposed treatment as explained to me and that I have had the opportunity to ask questions prior to treatment.

I understand that no guarantees or assurances have been made regarding the outcome of any dental treatment.

Risks and Alternatives

I understand that dental procedures carry certain risks, which may include but are not limited to:

- Pain or discomfort
- Swelling or bruising
- Bleeding
- Infection
- Temporary or permanent numbness
- Allergic reaction to medications or materials
- Failure of a restoration or treatment requiring additional care
- Loss or removal of bone during tooth extraction.
- Damage to, or fracture of, adjacent teeth or tooth restorations.
- Unforeseen complications that may require referral to a dental specialist

I understand that alternative treatment options, including no treatment, may be available and have the right to discuss these alternatives with the treating dentist.

Medical Information

I certify that I have provided complete and accurate medical and dental history information for my child and agree to notify the dental office of any changes in my child's health, medications, allergies, or medical conditions.

Consent for Emergency Care

If dentist determines that immediate treatment is necessary to relieve pain, control infection, or prevent serious harm to the patient's oral health, I authorize South Cove Community Health Center to provide appropriate emergency dental treatment.

Financial Responsibility

I understand that I am responsible for any charges not covered by my insurance or other third-party payer, subject to the Health Center's financial assistance policies and applicable regulations.

Acknowledgment

By signing below, I acknowledge that:

- I am the parent or legal guardian of the above-named child.
- I have read and understand this consent.
- My questions have been answered to my satisfaction.
- I voluntarily authorize South Cove Community Health Center to provide dental treatment as described above.
- I understand that I may revoke this consent at any time by providing written notice, except to the extent that treatment has already been provided.

Patient or if Patient is under 18 then Parent/Legal Guardian Signature

Name (Print): _____

Signature: _____

Date: _____