Dental Hygiene Consent Form

FOR THE PATIENT: Please read and sign before treatment. Parent or guardian must sign for a minor (a child under the age of 18).

1. Patients are expected to keep and to be on time for appointments.
   a. If a patient habitually cancels (without 24 hour notice), is habitually late, or does not show for appointments, we reserve the right to refuse further treatment.
   b. If a patient is late and the practitioner does not have time to treat the patient, the patient will need to reschedule.

2. Children under the age of 18 must be accompanied throughout the appointment period by a parent or guardian.

   a. A child may not be dropped off and left without a parent or guardian being present during treatment.
   b. If a parent or guardian must leave the child, arrangements must be made for the parent or legal guardian to leave a signed consent to treat form with the practitioner.
   c. Only the patient receiving treatment will be allowed in the treatment area. Other individuals accompanying the patient must wait in the reception area unless a practitioner specifically asks for someone to enter the treatment area.
   d. Children usually respond better to treatment when a parent or guardian remains in the reception area during treatment.

3. It is understood that:
   a. Radiographs (x-rays) must be taken as necessary for treatment.
   b. Patients may, upon a practitioner's request, pick up their radiographs, following evaluation by the consulting dentist, and take them to a dentist of their choice. Patients should contact the office to request that their radiographs be prepared for pick-up. A duplication fee may be required.
   c. Fluoride treatment will be provided to patients when indicated in protocol unless contraindications to such treatment are indicated.
   d. Treatment may be refused if, in the judgment of the practitioner, it is in the best interest of the patient to do so.
   e. It is possible that during treatment a defective restoration may be inadvertently removed. We do not assume responsibility for replacement of the restoration.
   f. Radiographs will be sent to a consulting dentist or the patient's dentist of record.

4. Payment is expected when services are rendered.
   a. If more than one appointment is needed to complete treatment, payment is expected at the first appointment.
   b. Only checks, cash, and credit cards are accepted as payment. Insurance and Medicaid will be accepted from eligible patients.

c. If payment is not rendered at the first appointment, we reserve the right to discontinue treatment.
d. If the patient chooses not to return to complete treatment, fees are not refundable.

5. Patients are required to answer all requests for information fully and truthfully.
   a. Patients should advise the practitioner of any allergies and/or other health problems.
   b. Practitioner will not perform treatment if the patient fails to provide adequate information.

6. The assessment received by the collaborative practice dental hygienist does not constitute a comprehensive dental examination. The patient should be seen by a dentist on an annual basis. If it has been indicated that further dental treatment is needed the patient should seek care by a dentist.

I have read, understand and agree to comply with the above policies and I request dental hygiene services that are necessary for proper treatment of my oral condition.

PATIENT'S OR GUARDIAN SIGNATURE (PARENT OR GUARDIAN) DATE

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_____ _____

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_____ _____

This is simply an example of what you might want to use. It may be added to or have things eliminated in order to comply with the situation between the CPDH and Consulting Dentist.

PATIENT'S NAME_____Date _____

Our services should not be substituted for a complete dental examination, a dental examination should be performed by a dentist at least every 12 months. We encourage further services from the family dentist. Our evaluation shows:

Urgent Need	☐
Earliest possible appointment	☐
Routine follow-up care encouraged	☐

COMMENTS:

_____

_____

Collaborative Dental Hygienists' Signature_____

Patient or Guardian

Signature_____

This is simply an example of a referral form. Please alter to make it comply with the CPDH and Consulting Dentist