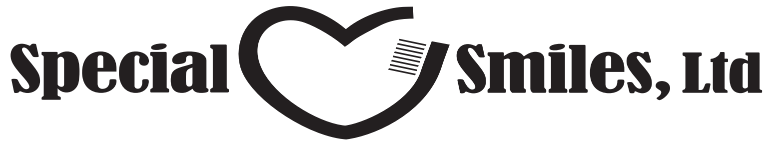

2301 E. ALLEGHENY AVENUE, SUITE 202, PHILADELPHIA, PA 19134
267-639-6250 TELEPHONE 267-639-6270 FAX
www.specialsmilesltd.com

CONSENT FOR COMPREHENSIVE DENTAL TREATMENT

PATIENT NAME: ____SURGERY DATE ___/_____/_____

It is the philosophy of our dental practice to preserve the entire dentition (set of teeth) of our patients. We recognize the importance of maintaining all teeth in order to support appearance, function, as well as the overall oral habits of our patients. We choose treatment options that are the best choice for each particular oral disease or condition a patient may have. Our treatment selections promote the overall and long-term health of the patient. We encourage you to contact us in order to speak with one of our dentists in advance of the patient's appointment should you have any questions.

I authorize the dentist(s) of Special Smiles, Ltd to provide comprehensive oral rehabilitation for the above referenced patient. I understand that the dental treatment may include, but is not limited to the following treatments: comprehensive examination, full mouth x-ray series, clinical photographs for record keeping and teaching purposes, cleaning, periodontal scaling and root planing, fluoride treatment, minor periodontal surgery, soft tissue excision and biopsy of lesions, amalgam and composite tooth restorations, stainless steel crowns, extractions and limited root canal treatment.

I understand that Special Smiles, Ltd. is a licensed tenant of City Center at Northeastern Hospital and that no services are being provided by Temple University Hospital – Health System Northeastern Campus.

ACKNOWLEDGEMENT

I hereby acknowledge that I have read and understand this consent, and that all questions about the proposed dental treatment have been answered in a satisfactory manner. I understand that Special Smiles, Ltd is an educational setting. As such, dentists in residency may participate/assist with dental treatment under the supervision of a staff dentist. I further understand that this consent form is invalid if altered but that I have the right to be provided with answers to questions, which may arise during the course of treatment.

I certify that I am the legal guardian of the above referenced patient or have otherwise been empowered to give consent on behalf of the patient. This consent shall remain in force for 60 days after date signed or unless otherwise terminated by me.

____ Date _____/_____/_____
Name of Parent/Guardian (please print full name)

____ ________________________________
Signature of Parent/Guardian Witness

____ ________________________________
Relationship to Patient Name of Witness (please print full name)

____
Phone Number of Legal Guardian