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CONSENT FOR COMPREHENSIVE DENTAL TREATMENT

PATIENT NAME: _____ D.O.B. _____ 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 Commonwealth Campus and that no services are being provided by Temple University Hospital.

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 have also been made aware that, by calling the front office at Special Smiles, Ltd. at 267-639-6250, I may schedule a phone meeting one of our staff dentists to ask any questions that I might have concerning the proposed treatment, any alternative methods of treatment, associated risks and the possible results of not receiving such treatment.

I further acknowledge that I have been given an opportunity to ask questions that I might have concerning the proposed treatment, any alternative methods of treatment, and associated risks and that I have been provided all information that I have requested.

A copy of the Philadelphia Department of Public Health Information Sheet regarding amalgam dental fillings has been provided to the patient (or patient's representative) and questions, if any, have been answered.

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. The Consent for Dental Care shall remain in force for 90 days after date signed or unless otherwise terminated by me.

Name of Parent/Guardian (please print full name)

Signature of Parent/Guardian

Date

Relationship to Patient

Phone Number of Legal Guardian