CONSENT FOR DENTAL EXAMINATION AND TREATMENT

PATIENT'S NAME _____

1. I understand the dental staff will perform an oral examination on my child or myself and provide needed dental care based on the dentist's findings. Dental treatments may include cleanings, fluoride, sealants, x-rays, fillings and extractions.
2. I understand that emergency dental treatment may be limited. Emergency procedures are generally done to relieve the patient from swelling, bleeding, infection and injury. Referrals to specialists or other facilities may be necessary.
   a. Upon signing this consent, I authorize Macon County Public Health Center's Dental Clinic to release all necessary information contained in my dental chart to other facilities including but not limited to: dental specialists, orthodontists and surgical care centers in order to continue my dental care.
   b. Upon signing this consent, I authorize Macon County Public Health Center's Dental Clinic to share copies of Treatment Plans and Treatment Schedules with agencies such as MPP's Head Start Program, Nursing Home Facilities, Physicians and DSS upon receiving written request from said facility for the purpose of coordinating care or your participation in their programs.
3. Sometimes problems can occur. I understand that there are risks in dental treatment; which may include pain/soreness, swelling, infection, bleeding, injury to nearby teeth or gums, problems with joints in the mouth or jawbone, numbness, and allergic reactions.
4. I have been given the opportunity to have all my questions answered and agree to have myself or my child participate in the dental clinic program.
5. Parents are required to remain in the waiting area during most dental procedures. In rare cases the dentist or dental staff may request the parents to be present in the treatment area. It is our goal to develop good patient behavior and the child's trust in the dental team. Our experience has shown that it is best when parents wait outside.
6. I understand, that should my child be unable or unwilling to keep his/her head, arms and or legs still, during a dental procedure, dental treatment cannot be safely provided. The child will be encouraged to sit still by using praise and explaining what the dentist is going to do. If the child is still not able to sit still, the parent will be encouraged to reschedule in six months to one year. If the patient has a dental emergency and is not cooperative, he/she will be referred to another source of care.
7. I understand that the dental clinic is for children and adults who are eligible and receiving Medicaid or NC Health Choice insurance. You are required to notify staff immediately when your insurance coverage changes. **I understand that if services are rendered to me and I am not eligible for Medicaid or NC Health Choice insurance, at the time of service that I will be responsible for any expenses incurred during that visit.**
8. I authorize the release of any dental information necessary to process any insurance claims. I authorize payment of dental benefits to the Macon County Public Health Center.
9. Should you fail to comply with the above stated responsibilities, the Macon County Public Health Center reserves the right to reschedule your visit, refer you to another practice or dismiss you from our dental clinic.
10. No more than two family members will be scheduled for dental care in any day. It is the patient's responsibility to keep all scheduled appointments or to cancel each appointment in a timely manner. Patients are expected to arrive on time for their scheduled appointment. Patients arriving more than 10 minutes past their appointment time will be treated as a missed appointment. If the patient fails to keep two appointments without canceling/rescheduling the appointment in such a manner, the patient will not be seen again by the Macon County Public Health Center's dental clinic.

_____ _____

Signature of Patient (Parent/Guardian if under 18) Date

_____ _____

Relationship to Patient Patient's Date of Birth