
Last Name First Name MI

Date of Birth



Macon County
Public Health

Consent for Dental Examination and Treatment

By signing this Consent:

1. I authorize Macon County Dental Services to provide all necessary dental care recommended. If the patient is a minor, as parent/guardian, I authorize consent without me being present for the procedures.
2. I understand the dental staff will perform an oral examination on myself/child and provide needed dental care based on the dentist's findings. Dental treatments may include but are not limited to; cleanings, fluoride, sealants, digital x-rays, fillings, extractions, limited replacement options such as partials or dentures, stainless steel crowns, space maintainer and pulpotomies.
3. In the event that my child needs a primary tooth (baby tooth) extracted, I give consent for this extraction
4. I understand the emergency dental treatment may be limited and is done to relieve pain, swelling, infection and injury.
 - a. If a referral to a specialist is required for continuity of dental care, a Release of Records Form must be completed.
 - b. I authorize Macon County Public Health to share copies of my Treatment Plans and Treatment Schedules with agencies such as Macon Program for Progress (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.
5. 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.
6. I have been given the opportunity to have all my questions answered and agree to have myself or my child participate in the dental program.
7. Macon County Public Health accepts Medicaid, NC Health Choice, patient pay and some private dental insurance plans. Patients who have no dental insurance may qualify for sliding fee scale based on your family size and income. 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 insurance, at the time of service that I will be responsible for any expenses incurred during that visit.
8. Failure to comply with the above stated responsibilities Macon County Public Health reserves the right to reschedule your visit, refer the patient to another practice or dismiss you from our clinic.

Signature of Patient, Parent, or Guardian

Date

Relationship to Patient