

PATIENT INFORMED CONSENT

I, _____ (patient), have been informed of my rights as a patient of the Regis Dental Center, the treatment needed for my oral conditions, the respective alternatives, advantages and disadvantages, risks, costs and the consequence of non-treatment. I understand that dental procedures may require a local anesthetic and/or nitrous oxide anesthesia. I understand that some of my procedures will be performed by students, under the direct supervision of the faculty and supervising dentist.

Patient Signature

IF PATIENT IS MINOR AND PARENT WILL NOT BE PRESENT AT APPOINTMENT, THIS SECTION MUST BE FILLED, ALSO.

I, _____ as parent/guardian, for _____ (minor patient) give permission for Regis Dental Center to take x-rays, administer fluoride and /or apply sealants prescribed by the supervising dentist.

PATIENT SIGN BELOW:

I understand the terms of this consent. I hereby authorize Regis Dental Center to perform such treatment for me _____
Parent Signature if patient is a minor

Patient's Date of Birth _____

Today's date _____

