

**Dental Care  
Consent for Dental Procedures & Privacy Practices**

Please read this form carefully and ask about anything you do not understand. For more information, call the Smart Smiles coordinator at the Boys & Girls Clubs of Martinsville Henry County at 656-1171.

I, the undersigned, hereby authorize and direct the Piedmont Virginia Dental Health Foundation Community Dental Clinic and/or any private dentists or dental offices associated with the Boys & Girls Clubs (collectively the "Dental Clinic") and the dentist or dentists providing services at these offices ("Dentist", whether one or more), assisted by other dentists or assistants of his or her choice, to perform upon \_\_\_\_\_ (the "Child"), a minor, the following dental treatment; except as indicated by a check mark below:

*(check only the form of treatment to which you **DO NOT** consent)*

- x-rays of the teeth and jaws
- Cleaning of the teeth and the application of topical fluoride
- Application of "sealants" to the grooves of the teeth
- Use of local anesthesia to numb the teeth and tissues
- Fillings
- Replacement of missing teeth with dental prosthesis
- Removal (extraction) of one or more teeth
- Treatment of diseased or injured oral tissues (hard and/or soft)
- Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities
- Use of medical immobilization to safely accomplish the necessary dental procedures
- Other (if none so state): \_\_\_\_\_.

1. I further authorize the Dental Clinic, the Dentist and any assisting personnel to perform any and all other dental service(s) that in the Dentist's judgment become necessary or are advisable for the Child, with the exception of (if none so state): \_\_\_\_\_.

2. I understand that the purpose and benefit of the treatment(s) indicated above is to preserve, maintain, and restore the Child's general dental health and/or to alleviate and prevent specific tooth and mouth pain.

3. Alternate procedures or methods of treatment, if any, have been fully explained to me, as have the advantages and disadvantages, the risks, consequences and probable effectiveness of each proposed treatment, as well as the prognosis if no treatment is provided.

4. I have been fully advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantees, expressed or implied, as to the result of the treatment or as to a final cure.

5. Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. The most common complications include nausea following the administration of topical fluoride and injuries caused by patients biting their tongue or lip following the administration of local anesthesia. Less common complications include the risks of numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing, or aspiration of a crown form, an extracted tooth or gauze packing, injury to the tongue and/or lips, damage to and possible loss of existing teeth and/or restorations (fillings), injury to nerves near the treatment site and fracture of a tooth root which may require additional surgery for its removal. For children with heart disease, the risk of sub-acute bacterial endocarditis (heart infection) following dental treatment exists; therefore, antibiotics will be prescribed before and following treatment to minimize the risk.

6. I further authorize the Dentist to use photographs, radiographs, and any and all other diagnostic materials and treatment records pertaining to the Child for the purposes of teaching, research, and scientific publication.

7. I further understand and accept that complications may require additional medical, dental or surgical treatment and may require hospitalization.

8. Assignment: In consideration of dental services to be rendered to me or the Child, I hereby assign to the Dental Clinic, to the extent necessary to satisfy any outstanding debts, all sums payable to or on behalf of myself or the Child, pursuant to any health benefit plan, or policy of insurance or pursuant to any settlement or judgment arising out of or related to any incident which led, directly or indirectly, to the above-referenced dental treatment. Any such payments should be made directly to the Dental Clinic.

9. Release of Information: I hereby authorize the Dental Clinic to release all of the Child's medical, dental and billing information to: (i) any physician or dentist involved in the Child's treatment; (ii) to any hospital, clinic or other health care facility to which the Child is transferred for treatment; (iii) to any affiliates of the Clinic or Boys & Girls Clubs for the purposes of billing, collection, and/or defense of litigation or anticipated litigation; and (iv) to any insurance company, review organization or other entity, which is directly or indirectly responsible for payment or review of services provided by the Dental Clinic.

I hereby state that I have read and understand this consent form; that all appropriate blanks of this form have been filled in; that I have been given an opportunity to ask any questions I might have; and that all questions about the procedure or procedures have been answered in a satisfactory manner. I understand further that I have the right to be provided with answers to questions, which may arise during the course of the Child's treatment.

I further understand that I am free to withdraw my consent to treatment at any time, and that this consent shall remain in effect until such time as I choose to terminate such consent and communicate the fact of such termination to the Dentist or to his/her representative.

I have received a copy of the Smart Smiles Notice of Privacy Practices and have had an opportunity to read the Notice of Privacy Practices. I understand that I may ask questions directly to the Smart Smiles coordinator or the Dental Provider if I do not understand information contained in the Notice of Privacy Practices.

Child's Name: \_\_\_\_\_

Consent Given By: \_\_\_\_\_ / \_\_\_\_\_  
Printed Name Signature

Relationship To Child: \_\_\_Parent \_\_\_Loco Parentis \_\_\_Guardian  
\_\_\_Department of Social Services

Date: \_\_\_\_\_