SENIOR MOBILE
DENTAL SERVICES

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Consent to Treatment

Patient's Name:

Facility's Name & Room #:

If the patient is unable, POA (Power of Attorney)/ family will consent.

POA/ Family's Name:

POA/ Family's Relationship to Patient:

I (*The patient or POA/ family*), hereby consent to the following dental treatment recommended by Senior Mobile Dental Services.

Description of Treatment:

For patients with natural teeth: Full mouth examination and diagnosis, x-rays, cleaning, antimicrobial treatment (rinse), and fluoride gel or foam treatment.
For patients without natural teeth (dentures only): Denture and soft tissue examination, cleaning.

Treatment consent capability: Is the patient capable of understanding the information about treatment and able to give consent to treatment? Yes ☐ No ☐

If patient is not capable:
I (*POA/ family*) will be present at each appointment Yes ☐ No ☐
Treatment can be provided in my absence Yes ☐ No ☐ Initial:

Consent:
I have had the chance to pose questions and have been provided with adequate answers addressing any issues I may have about the treatment. I consent to undergo the treatment as proposed by Senior Mobile Dental Services.

Consent for release of Patient information:
I (*The patient or POA/ family*) hereby consent to the release of (my or the patient's) medical information, personal health information and contact information to Senior Mobile Dental Services from (my or the patient's) Facility, doctors and other health care providers as is required by Senior Mobile Dental Services.

Signature of patient or POA/ Family:

Witness Signature (If signed by patient):

Date:

Witness Name: