21 DENTAL GROUP

Discussion and Informed Consent for Custom-Fitted Mouthguard

Patient Name: _____ Date: _____

Diagnosis: _____

Treatment: _____

Does the patient have any specific known allergies to: *(check only those that apply)*

☐ Latex ☐ Vinyl ☐ Plastics

Has the patient ever had an adverse reaction to a dental impression material?: *Yes / No (if yes, please explain)*

I, Huy Chung (please print your name clearly) am the parent/legal guardian of the above mentioned child and have the authority to give consent to treatment on behalf of said child

Treatment Limitations
Parent/legal guardian's initials required

_____ I understand that in this instance the treatment provided by Dr. is solely related to the construction of a mouthguard and does not constitute a comprehensive dental examination or dental screening. Dr. will not be taking X-rays, cleaning the teeth or diagnosing any dental condition.

Potential Risks or Complications

_____ I understand that a custom-fitted mouthguard can play a significant part in preventing injury to teeth during athletic competition and practice, but it does not guarantee that injury to the teeth, gum tissue, head and neck will not occur.

_____ I understand that loose teeth, fillings, crowns, veneers, orthodontic appliances or prostheses could become dislodged by the taking of the impression, which may require repair or treatment recommendation by my or my child's regular dentist or a dental specialist.

_____ I have been given an opportunity to ask questions regarding the procedure and all my questions have been answered to my satisfaction.

Check the boxes below that apply to you:

Consent

☐ I have been informed both verbally and by the information provided on this form of the risks and benefits of the proposed treatment.

☐ I have been informed both verbally and by the information provided on this form of the material risks and benefits of alternative treatment and of electing not to treat my condition.

☐ I certify that I have read and understand the above information and that the explanations referred to are understood by me, that my questions have been answered and that the blanks requiring insertions or completion have been filled in. I authorize and direct Dr. to do whatever he/she deems necessary and advisable under the circumstances.

☐ I consent to have the above-mentioned treatment.

☐ While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

or

Refusal

☐ I refuse to give my consent for the proposed treatment(s) described above and understand the potential consequences associated with this refusal.

Patient or Patient's Representative _____ Date _____

Witness Signature _____ Date _____

I attest that I have discussed the risks, benefits, consequences and alternatives of the above treatment with (Patient or Patient's Representative) and they have had the opportunity to ask questions. I believe they understand what has been explained and consents or refuses treatment noted above.

Dentist Signature _____ Date _____