ONE OR TWO DIGIT CANDIDATE NUMBER

Central Regional Dental Testing Service, Inc.
TREATMENT CONSENT FORM

DENTAL HYGIENE EXAMINATION

I, _____, authorize Candidate #_____,

a dental hygiene examinee, to perform upon myself the following dental hygiene procedures:

Patient Assessment: Extra/Intra Oral Assessment, Periodontal Measurements and Scaling/Calculus/Plaque/Stain Removal.

I understand that the examinee may not be a licensed dental hygienist. I further understand that such procedure(s) will be performed by the examinee as part of an examination conducted by Central Regional Dental Testing Service, Inc., to determine the qualification of the examinee for licensure. I recognize that medical information which could be pertinent to the oral health care I receive in the course of the examination may be transmitted to examiners.

The nature and purpose of the procedure(s) as well as the risks and possible complications have been explained to me. My questions with regard to the procedure(s) have been answered. I acknowledge that no guarantee or warranty has been made as to the results to be obtained. I understand that only a portion of my mouth will receive dental hygiene treatment today and that further treatment may be necessary. I have been informed of the availability of services to complete treatment.

I understand that if I am taking certain medications (as indicated on the Health History form) that are associated with chronic conditions following dental treatment, I may not be accepted as a patient for this examination. Patients who are taking oral bisphosphonate medications may be at risk for oral osteochemonecrosis of the jaws after dental treatment or as a result of dental infections.

I consent to the taking of appropriate radiographs (x-rays) and dental examinations.

I consent to having CRDTS examiners or school personnel take photographs of my teeth and gums for use in future examiner calibration provided my name is not in any way associated with these photographs.

I understand that as part of the dental hygiene procedure(s), it may be necessary to administer anesthetics and I consent to the use of such anesthetics by the dental hygiene candidate or other qualified persons.

DATED this _____ day of _____, 20___.

_____ _____
Patient's Signature or Parent or Guardian's Signature (if patient is a minor)

_____ _____ (____)_____
Patient's Address, City, State & Zip Patient's Phone Number