Candidate Number

Exam Site_____

Central Regional Dental Testing Service, Inc.

TREATMENT CONSENT FORM

DENTAL EXAMINATION

*Fill in the Candidate name below **after** the examination is over and **before** you turn in your packet.*

I,_____, authorize Candidate #_____, Candidate Name (added later)_____, a dental examinee and whomever the dental examinee may designate as an assistant or assistants, to perform upon myself the following dental procedure(s):

	Amalgam Preparation and Restoration
	Composite Preparation and Restoration
	Periodontal Treatment (Scaling, Supragingival Deposit Removal, Periodontal Measurements)

I understand that the dental examinee may not be a licensed dentist. I further understand that such procedure(s) will be performed by the examinee as part of an examination conducted to determine the qualification of the dental 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 communicated to examiners.

The nature and purpose of the dental procedure(s) as well as the risks and possible complications have been explained to me. My questions with regard to the dental 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 the treatment provided during the examination does not necessarily fulfill all my oral health needs or represent my entire treatment plan, and that further restorative and/or periodontal 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 Medical 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 a part of the dental procedure(s), it may be necessary to administer anesthetics and I consent to the use of such anesthetics by the dental examinee.

I understand that due to variables within the exam it may be necessary for me to be available through the conclusion of the exam day.

_____ DATE_____20_____.
Patient's Signature

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

This form may be copied as necessary for each patient utilized in the examination.