BUCYRUS
CAMPUS

**GARDETTO FAMILY COMMUNITY DENTAL CLINIC**

**CONSENT FOR TREATMENT**

Patient's Name: ________________________
Birthdate: ____________________________

I consent for ____________________ to receive dental treatment deemed necessary by the providers at St. Ann Center for Intergenerational Care, The Gardetto Family Community Dental Clinic.

These procedures include, but are not limited to; examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics including Nitrous Oxide. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

While SAC is affiliated with the Sisters of St. Francis of Assisi, it is a separate legal entity. The Sisters of St. Francis of Assisi are not involved, or responsible for, the care provided at SAC.

Guardian:_________________________________________________________________________

(print your name) (relationship) (date)

______________________________________________________________________________

____________________________________________________

(your signature) (witness) (date)

***This section needs to be completed by the legal guardian ONLY.***

I affirm that I am the legal guardian for the above named patient. If I am unable to accompany the patient, I give permission for the individuals named below to escort ________________________for dental treatments:

Name:_________________________________

Relationship:____________________

Name:____________________________________

Relationship:____________________

Name:____________________________________

Relationship:____________________

Name:____________________________________

Relationship:____________________

I understand that no invasive treatment, such as extractions or the
initiation of root canal therapies, will be performed unless I am notified by telephone. In the event of an emergency, when I cannot be reached, I give permission to perform whatever therapies are deemed necessary by the treating provider.

_____________________________________________________

(signature of legal guardian)

***This consent shall be considered in effect until rescinded or revoked.***