MINNESOTA STATE UNIVERSITY DENTAL CLINIC

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120 CLINICAL SCIENCES BLDG. | 150 SOUTH ROAD • MANKATO, MN 56001 (507)389-2147

Informed Consent

Patient Name: _____ _____ ___ _____

Last First MI Preferred Name

Treatment planned procedures and cost:

_____

_____

_____

_____

I, the undersigned patient, hereby authorize the undersigned provider to perform the procedure(s) or course(s) of treatment listed above. By entering a checkmark and signing this form I acknowledge that I understand: *

- ☐ -withholding information about my health history may affect the outcome of the procedure(s) and/or course(s) of treatment.
- ☐ -my dental condition and have discussed all treatment options with the undersigned provider. I have been offered an email of the procedure or treatment details and any post-op instructions.
- ☐ -that a dental exam may not be available during the appointment. Dental hygiene services alone do not substitute for a dental examination by a licensed dentist.
- ☐ -the risks inherent in the treatment(s).The provider has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment and that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and of the possible consequences of non-treatment.
- ☐ -my payment options, I accept full responsibility for the balance due on my account, including services not covered by my insurance plan (if applicable).
- ☐ I authorize any necessary life-saving procedures to be performed in the event of an emergency (including blood transfusions and/or medications as needed).
- ☐ I confirm I understand this form and information contained therein. I am a native speaker of English or have been offered the services of a qualified translator to explain this form.

I understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here. *

◯ I consent ◯ I do not consent

Local anesthetic may be recommended to increase my comfort during procedures. I understand that while rare, hemotomas, parathesia, and allergic reactions may occur from local anesthetics. *

◯ I consent, if needed ◯ I do not consent

Nitrous oxide sedation (laughing gas) may be recommended to make me feel more relaxed, comfortable, and less anxious during procedures. I understand I could experience headache, dizziness, nausea and/or vomiting and that some individuals experience a dream-like state or hallucinations. *

◯ I consent, if needed ◯ I do not consent

Name of Student Provider: *

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_____

Response Date: _____