DENTAL TREATMENT CONSENT FORM

Please read each paragraph carefully and sign in the appropriate area afterwards.

1. I understand that the University Dental Hospital at King Khalid University is an educational body and that a supervised student might be the prime treating dentist or part of the treating team.

2. My student and/or dentist responsible for my care will thoroughly brief me about any operation, procedure, technique or taking of any clinical x-ray related to the proposed treatment and that I may ask questions concerning it. I further understand that multiple visits are required by students to complete the examination and treatment plan.

3. I am aware that it is important to keep my dental appointment for failure to do so will cause loss of credit to the student and may result in depriving me from any further treatment in the hospital.

4. I understand that my proposed treatment should involve taking of intra-oral and extra-oral radiographs which enables the dentists to view dental cavities, abnormalities, development and eruption of teeth necessary for proper diagnosis and evaluation purposes.

5. I give my permission to make any/all changes and additions deem necessary because of conditions found while working on the teeth that were not discovered during examination.

6. I am aware that all records, radiographs (X- Ray films), photographs, casts...etc are the property of the University Dental Hospital at King Khalid University, and may be used for teaching purposes and/or scientific publication without additional consent.

7. I hereby state that I have read and understand this consent form, that I have been given an opportunity to ask questions and that all my questions have been answered to my satisfaction.

Name of Patient: _____

Signature of Patient/Parent/Guardian: _____

Date: _