Patient Sticky label

National University Polyclinics
A member of the NUHS

CONSENT FOR DENTAL TREATMENT / OPERATION / PROCEDURE (for Minors under 21 years old)

I consent to the following treatment/operation/procedure at the Dental Clinic, National University Polyclinics for
□ Self □ Child □ Ward named above :

- **Examination & Referral:** Examine teeth to detect decay, other conditions and to refer patients for follow up treatment at other healthcare institutions if needed
- **Radiographic Examination (X-rays):** Detect dental structures, bone loss, cavities and abnormalities not visible in the mouth
- **Restorations (fillings):** Remove decay and replace lost tooth structure
- **Scaling & Polishing:** Remove tartar, stains and plaque
- **Topical Fluoride Application:** To apply Topical Fluoride to prevent and control decay

*Note: Please delete any procedures that are not applicable.

I understand that the advice and explanation given to me by the dentist have taken into account my personal condition/ circumstances These include:

a. The diagnosis of my dental condition;
   The nature, purpose, risks and potential complications of the treatment/operation/procedure. (The potential complications are not exhaustive and the actual risk to me depends on my underlying medical/medication condition, predisposing factors and the nature of the Treatment);
b. The consequences of non-treatment; &
c. The availability/possibility, advantages/disadvantages, and risks of alternative treatment.

I acknowledge that I have been given the opportunity to ask questions and express my concerns; and any related concerns of mine have been addressed. No assurance has been given to me that a particular dentist will perform the treatment/operation/procedure or that the outcome is guaranteed.

I also consent to:

- **The administration of local anaesthesia, drugs and medication**, &
- **The taking of radiographs, digital images and videographs for the purpose of diagnosis and treatment**.
  (I understand my personal identity will be kept confidential if these records are used for research and teaching)

*Note: Please delete any procedures that are not applicable.

I am aware that/of: (i) The estimated treatment/operation/procedure charges and understand that additional costs may be incurred if there are changes to the treatment plan; (ii) It is important to keep to the scheduled appointments as treatment may be terminated if there is repeated absence; & (iii) No refund will be given for treatment that has already been performed. If applicable, I acknowledge and understand that I am encouraged to accompany my child/ward for his/her dental appointment, so that I can better understand the care and treatment plans.

Date _____

---------- Signature of **Patient** * Name: NRIC/FIN/Passport:	I confirm I have advised and explained the above, including the nature, purpose, risk, potential complications of the treatment / operation / procedure: ---------- Signature of **Dentist** Name: DCR No:
---------- Signature of **Parent/Legal Guardian** Name: NRIC/FIN/Passport:	Explained / Interpreted / Witnessed by: ---------- Signature of **Explainer/Interpreter/Witness**: Name: NRIC/FIN/Passport: Language used for interpretation (if applicable):

** If Patient is below 21 years of age and is not a National Serviceman/woman, his/her Parent or Legal Guardian must also sign this Consent Form.*

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HEALTH QUESTIONNAIRE – CHILD

1. Has your child ever experienced any of the following symptoms on exertion?

	Yes	No
Chest pain	☐	☐
Breathlessness	☐	☐
Palpitation	☐	☐

2. Does your child have the following?

	Yes	No
Heart Disease *e.g. Valve replacement/ASD/VSD/Fallot's Tetralogy*	☐	☐
High Blood Pressure/Blood Disease *e.g. G6PD/Haemophilla/Thalassemia/*	☐	☐
Chronic cough/Asthma	☐	☐
Diabetes	☐	☐
Stroke	☐	☐
Epilepsy	☐	☐

3. Is your child on any long term medication? E.g. Steroid, Therapy, Antibiotics. If yes, please specify.

4. Does your child have any allergies? E.g. Drug allergy. If yes, please specify.

5. Is your child a carrier of any infectious disease? E.g. Hepatitis/Hepatitis Carrier.

6. Is there any significant past medical or family history? E.g. Heart Operations. If yes, please specify.

Name of parent / Guardian :

IC/FIN No. :

Contact Number :

Signature of Parent/Guardian

Adapted with permission from NHGP Dental Services
PM-DEN-002.F01 Health Questionnaire