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.*