HUDSON HEADWATERS
ALBERT R. TUCKER DENTAL CENTER

☐ Patient or Legal Representative refused to sign/complete this document.

GENERAL DENTAL CONSENT AND AGREEMENT

We have developed the following agreement to ensure a long and healthy relationship together. Please read the following information carefully. After you have read this consent and agreement, please sign your name indicating your acceptance of the terms of this agreement. By signing this document, you understand the agreement and consent in full, and you have had all of your questions answered to your satisfaction.

- I, _____ (*Patient's name*), _____ (*date of birth*) agree to permit the providers, residents, learners and staff of Hudson Headwaters Health Network (HHHN) to provide dental care to myself, child or legal ward as applicable.

- I understand that HHHN offers prevention-focused care, with limited appointments available for filings and other services.

- I agree to abide by HHHN's *Patient Responsibilities* and understand that these responsibilities are posted in all health centers, online and physically available to me upon request.

- I understand that HHHN maintains the right to discontinue treatment for any violation of these responsibilities, such as failure to maintain a consistent appointment schedule or inappropriate behavior. In such cases, the patient or parent/guardian agrees to accept full responsibility for pursuing alternate professional dental care.

- By signing below, I am indicating that I understand the terms of the consent agreement and that I have the legal authority to give consent for myself, child, or legal ward. I hereby give consent to HHHN to perform these procedures:
    - Examination
    - Oral prophylaxes (cleaning)
    - Radiographs (x-rays)
    - Local anesthesia
    - Fluoride treatments
    - Sealants
    - Oral hygiene instructions
    - Periodontal (gum) treatments
    - Restorations (amalgam or composite fillings and crowns)
    - Prosthetics
    - Emergency Care

- I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia.

- I understand that any dental procedures not listed above will require an additional consent and agreement to be completed prior to the procedure being performed.

- I understand that my care team may include dental residents, students or other trainees. A dental resident is a doctor who has graduated from dental school and is undergoing further clinical training. I understand that the dental resident may perform all or parts of my care. I understand that I have the right to refuse this arrangement at any time.

- I understand my provider leverages technological tools and resources including those which leverage artificial intelligence in the delivery of my care.

- I agree to emergency care as necessary, and the services performed at the request of my providers, residents or others assisting in my care. I understand that I have the right to refuse treatment at any time.

- I understand that dentistry is not an exact science and as such, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment plan which I have requested and authorized. I have had the opportunity to read this form and ask questions, and my questions have been answered to my satisfaction.

_____	_____	_____
Signature of Patient or Representative Authorized by Law	Print Name	Date