MHC Healthcare
Quality healthcare with a heart!

Consent for Dental Treatment and Privacy Notice

Patient Name (please print)_____

Date of Birth_____ Phone Number_____

Name of person completing this form_____

Address_____ City_____State____ Zip_____

Indicate Relationship to Patient _____ I am patient _____ Parent _____ Grandparent

_____ Legal Guardian _____ Parent Rep. _____ Other

Legal Guardians are required to present legal documentation demonstrating authorization to make medical/dental decisions for a minor or dependent or incompetent adult. Grandparents, Parent Representatives and others are required to have written authorization to approve treatment for a minor child. We also require a phone number to reach the parent. The custodial parent must sign and date the letter for the date of service and must include the name of the person accompanying the minor. A photocopy of an acceptable signature bearing ID (Drivers License) of the parent and the letter containing the appropriate information may be used.

I consent to diagnostic x-rays, examination, treatment planning, as well as all necessary dental treatment to correct the dental conditions diagnosed by the dentist. I also consent to the use of dental anesthetics and any further diagnostic x-rays that may be necessary to successfully complete my dental treatment.

I acknowledge that this consent is given only after the treatment plan options with associated risks and benefits have been explained to me by the dentist and dental staff. This consent shall remain in effect unless the patient, parent or legal guardian revokes consent in writing to dentist.

I acknowledge that Marana Health Center is a teaching facility. We host student dentists from the Arizona School of Dentistry and Oral Health and other ADA accredited training schools including student hygienists from Pima Community College Dental Hygiene program to provide treatment in our clinics. Every student is directly supervised by a staff dentist during all phases of treatment. It is your right to refuse treatment from a student at any time, this refusal must be provided in writing and the refusal form may be obtained from dental front office.

I consent to diagnostic x-rays, examination, treatment planning, as well as all necessary dental treatment.
I acknowledge my responsibility to pay for the treatment according to the established fees.
I acknowledge and consent that I may be seen and treated by a student dentist or student hygienist that will work under the license of the staff dentist. I understand my right to refuse treatment from students.

Privacy Notice

By signing this form, I am consenting to Marana Health Center's use and disclosure of my Protected Health Information, including information related to psychiatric care, drug and alcohol abuse, HIV/AIDS, and use of e-prescribing to obtain my medication history, for the purpose of carrying out treatment, payment and healthcare operations. I have been provided or offered a copy of Marana Health Center Privacy Statement.

Signature of Patient, Parent or Legal Guardian Date