CMADC
COMMUNITY MEDICAL & DENTAL CARE

CONSENT FOR DENTAL TREATMENT

I, _____, seek services for a condition requiring dental care. I voluntarily consent to such care including routine diagnostic and therapeutic procedures and dental treatment to be provided by the dentists, and/or dental staff and personnel of CMADC. I understand that this treatment will be provided according to acceptable dental standards. This consent has been fully explained to me and I certify that I understand its contents. I understand that I can revoke this consent at any time.

_____ _____
Signature of Patient Date

_____ _____
Signature of Relative or Legal Guardian Date

_____ _____
Signature of Witness Date

If a relative or legal guardian has signed for the patient, the following information must be provided.

I am signing for the patient because:

(a)_____ The patient is a minor and is unable to consent.
(b)_____ The patient is unable to consent because _____

_____

The witness must be someone other than the dentist obtaining the consent. The witness is attesting only to the fact that the patient or other appropriate person has signed the form.

□ **Monsey Medical and Dental Center**
40 Robert Pitt Drive
Monsey, NY 10952
845-352-6800
Fax 845-352-7292

□ **Dental Care on Wheels**
40 Robert Pitt Drive
Monsey, NY 10952
845-352-6800
Fax 845-352-7292

□ **Ben Gilman Spring Valley Medical and Dental Clinic**
175 Route 59
Spring Valley, NY 10977
845-426-5800
Fax 845-356-0433