

Cleona Dental, LLC
221 W. Penn Avenue, Suite 213
Cleona, PA 17042
(717) 272-8500

Consent for Dental Screening and Evaluation

Patient Name: _____

Social Security Number: _____

Date: _____

I hereby consent to a dental examination by Dr. Jennifer Davis and/or Dr. Frederick Johnson. Completion of a thorough examination, (radiographs, photographs, study models and intra oral examination) will need to be performed prior to appropriate diagnosis and treatment recommendations. Multiple treatment options will be offered if appropriate for a person's oral and systemic condition.

Patient's or Legal Guardian's/Representative's Signature

Date

I have explained the nature, purpose, risks, complications, benefits and alternatives to the proposed treatment, as well as the risks and consequences of proceeding or not proceeding with the treatment. I have answered all of the patient's questions, and I believe the patient/guardian/representative fully understand my answers and explanations.

Patient's or Legal Guardian's/Representative's Signature

Date

COPY OF THIS SIGNED DOCUMENT TO BE PLACED IN PATIENT'S CHART