



**Allied Dental Education Department**

**CLIENT REGISTRATION & CONSENT FORM**

Please read the following information carefully so that you will understand the conditions under which clients are treated at this clinic.

1. This is an educational setting. Dental Hygiene care in the clinic will proceed more slowly than in a private dental office as student services are carefully reviewed by faculty members. Although it is the goal to complete all procedures for clients, completion cannot be guaranteed in any specific number of appointments due to the varying needs of clients and students.
2. A comprehensive Dental Hygiene care plan will be formulated for each client. However, clients should not assume that students can diagnose and inform them all of treatment that needs to be done.
3. Students are required to obtain a medical and dental history of each client prior to initiating any procedure. Such information is confidential and considered essential for the performance of adequate Dental Hygiene treatment.
4. Clients are expected to keep appointments and arrive on time. Students depend on clients to complete course requirements. Failure to keep scheduled appointments may result in dismissal from the clinic.

**Dental Hygiene care in this setting does not replace the comprehensive dental care that can be provided in a dental office. We recommend you see your family dentist regularly.**

The Allied Dental Education Department reserves the right to refuse treatment if the health and/or safety of the client, student or faculty are in question.

**Federal Governmental Statistical Information (Optional)**

Sex:  Female :  Male :  Date of Birth: \_\_\_/\_\_\_/\_\_\_ Is English your primary language? Y N

**Ethnic Background:**

American Indian/Alaskan     Asian     Hispanic     Black, Non-Hispanic  
 Native Hawaiian/Pacific Islander     Non-Resident/Alien     White, Non-Hispanic

Having read the above, I verify that I understand the information contained therein and I grant the authority to the Allied Dental Education Department to perform treatment procedures deemed necessary for:

Client's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature: \_\_\_\_\_ Email address: \_\_\_\_\_