

PATIENT BILL OF RIGHTS

Welcome to the Ferris Dental Hygiene Clinic. This facility provides the opportunity for our dental hygiene students to receive their clinical experience in preparation to become licensed professional dental hygienists. The services provided by the student dental hygienists are under the supervision of licensed dental hygienists and dentists.

These services include: extra and intraoral examination, blood pressure screening, oral hygiene evaluation and instruction, x-rays for diagnosis by a dentist, oral data gathering (periodontal probing, hard tissue charting), oral prophylaxis, topical fluoride applications, and pit and fissure sealants.

As a patient in the clinic, you are entitled to considerate, respectful and confidential treatment which meets the dental hygiene profession's standard of care. You should expect to be informed of the treatment recommended and alternatives, the option to refuse treatment, the risk of no treatment, and the expected outcomes of various treatments. You should expect to know the cost of the treatment in advance. You should expect to be kept informed on the status of your condition and the anticipated length of time for treatment to be completed.

The dental hygiene care that you receive is **NOT** a substitute for your regular, periodic examination at your own dentists. **We encourage you to contact your dentist for a dental examination so that he/she can determine your additional dental needs.**

INFORMED CONSENT FOR DENTAL TREATMENT

I authorize the performance of dental services on _____
(myself or name of patient)

I have read the Clinic Information listed above. I understand that the services received here are not intended to replace a regular, periodic examination by my private dentist.

I understand that the dental procedures, the medical services rendered in conjunction therewith, and the post-operative care are to be performed and rendered by those individuals, including students, selected and deemed qualified by the dental teaching staff of Ferris State University.

I also authorize Ferris State University's medical and dental staff to administer topical or local anesthesia or medication as deemed necessary for my treatment.

I authorize Ferris State University to use my pictures, radiographs, records, models, or any reproductions of the same for the purpose of classroom illustration, publicity, or dental publication. I will hold Ferris State University free from any encumbrance or liability with respect to the above mentioned photographs, radiographs, records, models, or any reproduction of the same.

I authorize Ferris State University to release my x-rays or dental records to my private dentist as requested. I agree that Ferris State University Dental Hygiene Clinic may send my radiographs in an electronic format and at my request will send them to the email address provided by the dentist of my choice. I am aware that there is some level of risk that third parties might be able to read unencrypted email.

I understand that there may be circumstances where I may be reappointed, referred to a private dentist, or denied treatment if it is determined that my obtaining treatment is not in my best interest or that of the Clinic.

I hereby certify that I am of legal age and responsible to accomplish this release, and have read and understand the Patient Bill of Rights above.

Witness _____ Signature _____
Patient, Parent, or Guardian

Consent expires 12 months from date of signature. Date _____