National Healthcare Group
POLYCLINICS

Patient Sticky label

CONSENT FOR DENTAL TREATMENT / OPERATION / PROCEDURE (Under 21)

1) Examination & referral
2) Radiographic examination (X-rays)
3) Restorations (fillings)
4) Scaling & Polishing
5) Topical fluoride application

I consent to investigations, treatment/operation/procedure at the Dental Clinic, National Healthcare Group Polyclinics for

☐ self ☐ child ☐ ward named above.

I also consent to, where necessary:

a. The administration of local anaesthesia, drugs and medications
b. The taking of radiographs/digital images/ videographs for purpose of diagnosis and treatment. (Personal identity will be kept confidential if these records are used for research and teaching)

I understand the explanations given. These include:

a. The nature, purpose, risks and potential complications of the treatment/operation/procedure.
b. The consequences of declining treatment.
c. The availability of alternative treatment, if any.

We will like to encourage you to accompany your child/ward for his or her dental appointment, so that you can better understand our care and treatment plans.

I acknowledge that I have been given the opportunity to address any related concerns. No assurance has been given to me that a particular dental practitioner will perform the operation/procedure or that the outcome is guaranteed.

I am aware of the estimated treatment charges and understand that additional costs may be incurred if there are changes to the treatment plan. It is important to keep to the scheduled appointments as treatment may be terminated if there is repeated absence. No refund will be given for treatment that has already been carried out.

Dated: Signature

I confirm that I have explained the nature, purpose, risk, potential complications and estimated costs of the above stated procedure.

Dated: Signature

☐ Witness ☐ Interpreter ☐ Language:

Dated: Signature

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HEALTH QUESTIONNAIRE

1. Has your child ever experienced any of the following symptoms on exertion?

	Yes	No
Chest pain	☐	☐
Breathlessness	☐	☐
Palpitation	☐	☐

2. Does your child have the following?

	Yes	No
Heart Disease *e.g. Valve replacement/ASD/VSD/Fallot's Tetralogy*	☐	☐
High Blood Pressure/Blood Disease *e.g. G6PD/Haemophilla/Thalassemia/*	☐	☐
Chronic cough/Asthma	☐	☐
Diabetes	☐	☐
Stroke	☐	☐
Epilepsy	☐	☐

3. Is your child on any long term medication? E.g. Steroid, Therapy, Antibiotics. If yes, please specify.

4. Does your child have any allergies? E.g. Drug allergy. If yes, please specify.

5. Is your child a carrier of any infectious disease? E.g. Hepatitis/Hepatitis Carrier.

6. Is there any significant past medical or family history? E.g. Heart Operations. If yes, please specify.

Name of parent / Guardian : _____

IC/FIN No. : _____

Contact Number : _____

Signature of Parent/Guardian