



School of Dentistry

Consent for Care

I, the patient; and/or the patient’s legally authorized surrogate decision maker, hereby grant permission to the University of Washington School of Dentistry (UWSOD) Student Clinics and the University of Washington Dentists & Oral Surgeons, collectively “UW School of Dentistry”, to perform such examinations, and medical/dental and therapeutic procedures as may be professionally deemed necessary or advisable for my/the patient’s diagnosis and treatment.

I acknowledge that the UW School of Dentistry is a teaching institution and that teachers, trainees and students may observe or participate in the care provided.

I also give my permission to the University of Washington School of Dentistry and its representatives to make and use x-rays, photographs, and/or video recordings of the person named in this consent as deemed necessary for any diagnostic, treatment, or educational purpose. I have full knowledge that these forms of media may be necessary and proper to the interests of health education, knowledge or research by the School of Dentistry and that if used in any publication, I shall not be identified by name.

I have read and understand the above and hereby affix my signature.

SIGNATURE (PATIENT OR GUARANTOR)		DATE	
WITNESS (NAME AND TITLE)			
IF SIGNED BY PERSON OTHER THAN PATIENT, PROVIDE REASON AND RELATIONSHIP TO PATIENT		GUARANTOR <input type="checkbox"/> SAME AS PATIENT OR PERSON RESPONSIBLE FOR PAYMENT	DATE SUBSCRIBER ONLY DATE

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