BULLHOOK
Community Health Center

*521 4th St. – Havre, MT 59501-3649 ** Phone 406-395-4305 Fax 406-395-5643*

Informed Consent for Dental Prophylaxis

Patient:_____gives permission for_____RDH to perform the prescribed treatment of dental prophylaxis.
It has been recommended by your general dentist at the Bullhook Community Healthcare Center that you receive a prophylaxis (cleaning) by a Registered Dental Hygienist.
Dental cleanings are essential for maintaining health in your mouth. Overtime, bacteria, food debris, and calcified (hardened) material can accumulate on your teeth that your tooth brush cannot remove. Some people get this accumulation much quicker and in greater amounts than others. It may be recommended that you receive professional cleaning every 3, 6, or 12 months depending on your level of need.

At the appointment:

1. Removal of plaque and calculus with metal instruments and/or ultra-sonic scalers
2. Coronal polishing
3. Flossing of teeth
4. Taking of radiographs (X-Rays)
5. Application of Fluoride
6. Provide Oral Hygiene Instruction

Benefits:
Remove plaque and calculus that can aid in development of cavities or gum disease
Instruct patient in proper homecare
Prevent pre-mature loss of teeth from gum disease
Make teeth more resistant to cavities with the application of fluoride

Risks:
Teeth may become sensitive to air, hot and cold stimuli
TMJ (Jaw Joint) may become tender due to prolonged mouth opening
Tenderness may be present in the gums for a short time after a cleaning

I acknowledge that all procedures and costs have been explained to me and I give my consent for treatment.

Patient/Guardian:

_____Date:_____

Witness:_____Date_____