restoring smiles

PATIENT AGREEMENT FORM

1. I, _____ ***(name)***, will be matched with a dentist who will complete an oral examination and create a treatment plan for me. All dental work identified in this plan will be completed at no cost to me, and I will receive treatment at no-charge until the Treatment Plan is complete.

2. I understand that Restoring Smiles does not provide dental treatment for life, nor does it provide dental treatment to my family members.

3. I understand that I may be referred to other practitioners as part of my Treatment Plan.

4. I understand that all dental treatment identified in my Treatment Plan is undertaken by practitioners in the Restoring Smiles network on a volunteer basis.

5. I will respect my practitioners' time and appointment bookings. I will give 48 hours' notice if I am unable to keep an appointment time. (Patients who cancel without notice will be dismissed from the program at the dentist's discretion.)

6. I am entitled to trauma-sensitive care from practitioners. Male practitioners must have a female dental assistant present in the examination room at all times.

7. My personal information will be held in the strictest confidence, and I understand that my name, contact information, and details of treatment are only available to the practitioners and Restoring Smiles administrative staff.

8. If before and after photos are taken, all identifying features will be obscured. Photos are never released under any circumstances to anyone other than the Foundation's clinical board and Restoring Smiles administrators. No identifying information of any kind is ever released without my written consent.

9. I acknowledge that dental care would be a financial hardship.

10. I understand that, based on the Foundation's discretion, I can be dismissed from the Restoring Smiles at any time.

I agree to the terms above and wish to proceed with dental care with Restoring Smiles.

Name: _____

Signature: _____

Date: _____