Southern Indian Health Council, Inc.
4058 Willows Road, Alpine CA 91901-36350 Church Road, Campo, CA 91906
(619) 445-1188 Fax (619) 659-3135

GENERAL CONSENT FOR DIAGNOSIS AND TREATMENT

Name of Patient/DOB_____Adult____Minor_____

I consent to examinations, diagnostic procedures and treatment by Southern Indian Health Council, Inc. dentist, dental hygienists and their assistant. I have provided an accurate medical and dental history to them.

I consent to the use of local anesthetic and I understand there is a slight chance of an allergic response, muscle soreness and reactions to local anesthetic and medication prescribed, I have informed the dentist of all allergies that I have.

This consent shall remain in effect as long as I utilize the SIHC clinic and it will remain in effect unless I revoke it in writing.

I have been offered a copy of the Southern Indian Health Council's Dental Materials Fact Sheets as required by law.

For minor dependents patients only:

If minor or other dependent patient will be accompanied to the clinic by adult person other than the parent(s) or legal guardian, please list their name(s) and relationship below:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

By signing below, the patient/guardian acknowledges the above statements have been read. This consent shall remain in effect as long as the patient utilizes the services of Southern Indian Health Council unless revoked in writing.

NOTICE OF PRIVACY PRACTICES/ADVANCE HEALTH CARE DIRECTIVE

I acknowledge I have been offered a copy of Southern Indian Health Council's Notice of Privacy Practices and Advance Health Care Directive.

By signing below I acknowledge **RECEIPT** **REFUSAL** of the documents
(Circle one)

Print Name:_____ Date_____

Signature:_____ Date_____ **Patient** **Guardian**
(Circle one)

Relationship to Patient:_____ Witness:_____