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Informed Consent for TeleDentistry – Patient Acknowledgement

Patient Name: ______________________________

Date of Birth: ______________________________

I am acknowledging that I wish to receive a teledentistry consultation with my dentist. In the absence of radiographs (x-rays):

- I understand that I may be asked to send photographs or other documentations as requested by the dentist. I will try to provide as much detailed information as I can.
- I understand that the doctor is limited to what he is able to determine in these circumstances.
- I also understand that if I am experiencing pain or swelling that is life threatening, I will call 911 or go to an emergency room
- I understand that I am responsible for any payment resulting from this consultation. If you have dental insurance, a claim can be filed on your behalf and any dental benefit will be sent directly to the you.
- I understand and consent to this consultation being recorded for clinical documentation and accuracy

____
Print your name and sign and date below

____
Signature

____
Date

Relationship to patient (if signed by a personal representative of patient):

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