



Dental Hospital, Faculty of Dentistry, Prince of Songkla University

Consent Form for Dental Treatment by Dental Students at Main Clinic 2

I, Age years, HN

have voluntarily agreed to receive dental treatment provided by dental students at Main Clinic 2.

I have read and understood the information regarding treatment by dental students as follows:

Scope of Treatment Services

1. Tooth fillings and pit and fissure sealants
2. Dental scaling
3. Root canal treatment for anterior or premolar teeth
4. Fixed prosthodontics (crowns or bridges)
5. Removable partial dentures (acrylic or metal framework base)
6. Complete removable dentures

Note: In case the treatment is beyond the student's capability, the patient will be referred to a specialist or another appropriate clinic. The patient shall be responsible for any fees according to the rates of the referring clinic.

Treatment Procedure

1. During the first visit, a thorough oral examination will be conducted to develop a treatment plan. Patients will be given the opportunity to participate in treatment planning with the student.
2. The student will treat the patient at Main Clinic 2 under close supervision of faculty dentists, following professional dental standards until treatment completion. The patient will be scheduled for a follow-up oral health check-up every 6 months.
3. During treatment, intraoral and extraoral radiographs and photographs may be taken for treatment planning, clinical management, and educational purposes.

Treatment Schedule and Conditions

1. Appointments will be scheduled 1–2 times per week, each lasting 3 hours, Monday to Friday, from 9:00 AM to 4:00 PM (*excluding Wednesday afternoons and Friday afternoons when the clinic is closed*).
2. If the patient fails to attend more than 3 appointments without proper notice, or cannot commit to scheduled appointments, the patient may be dismissed from the student care program and referred to another clinic in the dental hospital.
3. If the patient behaves inappropriately for an educational setting, provides false information, or deliberately withholds relevant medical information, they may be dismissed from the program and referred appropriately.

Patient Benefits

1. Patients with medical benefits (e.g., direct billing, Universal Health Coverage) will use their eligible rights first.
2. Patients who self-pay or pay costs exceeding their entitled coverage may enter the “Bright Smile Program” and receive the following benefits:
 - 2.1 Waiver of fees for intraoral radiographs, panoramic radiographs, tooth fillings, sealants, scaling, and anterior/premolar root canal treatments
 - 2.2 50% discount for crowns, bridges, partial dentures, and complete dentures
(Note: The patient is responsible for the full cost of external dental lab work)

Declaration

- ☐ I accept all the above conditions and agree to receive dental treatment by dental students.
- ☐ I consent to allow the Faculty of Dentistry, Prince of Songkla University, to collect, use, and disclose my personal information including medical records, radiographs, photos, dental models, medical history, examination, treatment, and pathology data for educational and examination purposes according to the requirements of the Dental Council, as well as for treatment follow-up.

My name and personal data will be kept confidential. However, despite efforts to conceal my identity, there remains a possibility that someone might recognize me.

I understand that I may withdraw my consent at any time. Withdrawal will not affect any data previously given or the standard of dental care provided.

In case of any complications resulting from procedures conducted under professional standards, I will not claim compensation from the Faculty of Dentistry Hospital.

I acknowledge and agree to the information above by signing below as evidence of consent.

Signature:
(.....)

Treating Dentist

Signature:
(.....)

Patient/Authorized Representative

Relationship to the patient:

Signature:
(.....)

Witness

Signature:
(.....)

Witness

Date: Time:

Note:

1. If the patient comes alone, please note “Patient came alone” in the witness signature field.
2. If the patient is under 18 years old, a parent or guardian must sign the patient/guardian field.