Patient Authorization for Clinical Observation

_____(Name of Dental Office) partakes in clinical observation programs to give participants interested in a course of study related to a career in dentistry; including dentistry, dental hygiene, dental assisting, and office management, the chance to gain observational experience in clinical practice. Your dentist has agreed to permit those interested to observe in his/her daily patient care activities.

By signing below you agree to permit such participants working in your dentist's office to observe in your dental care during your appointment today. You agree that you have been given the opportunity to refuse to give such consent and that you may withdraw your consent at any time during your appointment.

_____
Patient Name

_____ Date: _____
Patient Signature

_____
Witness Signature

IF PATIENT IS UNABLE TO CONSENT OR IS A MINOR COMPLETE THE FOLLOWING:
This patient, whose name is written about, is a minor, _____ years of age or is otherwise unable to consent to and execute this document for the following reason:

_____

I hereby execute this document on the patient's behalf. I have read and fully understand each part of this document. I represent and verify that I am authorized to execute this document on behalf of the patient named above. I understand that I am entitled to receive a signed copy of this document.

_____
Signature of Caregiver

_____ Date: _____
Relationship to Patient

_____
Witness Signature