



**Consent to Diagnosis and Treatment**

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information.

I consent to the collection, use or disclosure of personal information as required for my own or my dependants dental care. I hereby authorize the doctor to take radiographs (x-rays), study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs. I authorize the doctor to perform any and all forms of treatment, medication and therapy, that may be indicated and consent to the use of local anesthetic agents.

I understand the above statement regarding the payment of fees and accept the responsibility for payment for dental services provided for myself or my dependants, due and payable when services are rendered unless other financial arrangements have been made.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Responsible party: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**Privacy Policy**

We are committed to protecting the privacy of our patients' personal information and to utilizing all information in a responsible and professional manner. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information such as names, home addresses, work addresses, home telephone numbers, cellular numbers and e-mail addresses (collectively referred to as "Patient Contact Information"). Patient contact information is collected and used for the following purposes:

- To open and update patient files.
- To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts.
- To process claims for payment or reimbursement for third-party health benefits providers and insurance companies.
- To send reminders to patients concerning the need for further dental examination or treatment.
- To send patients information material about our dental practice.

Financial information will be collected in order to make arrangements for the payment of dental services provided, unless the dental services are paid for in full at the time of visit.

We collect information about health history, family health history, physical condition, and previous dental treatments. Patients' medical information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

**Patients' medical information is disclosed:**

- To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to is obtaining the second opinion.
- To other dentists or specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialists for treatment.
- To other health care professionals such as physicians.

If information is no longer required, all pertinent documents are destroyed through on site shredding.

If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access as part of the due diligence process to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

Dentists are regulated by the Yukon Dental Association which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

I consent to the collection, use and disclosure of my personal information as set out above.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Date: \_\_\_\_\_