Consent for Treatment & Office Policies

CHILD'S NAME FIRST / LAST	TODAY'S DATE: DD / MMM/ YYYY

PARENT / GUARDIAN CONSENT FOR MINORS (<19 Years)

I, the undersigned, consent to Dr. Coveney, Dr. Grant, Dr. Santos and/or Dr. Yu, assisted by their dental staff, to perform an examination and dental and/or oral surgery procedures deemed to be necessary or advisable, including, but not limited to, the taking of radiographs (dental x-rays), use of diagnostic aids, and use of local anesthesia on my child. I also consent to the release of any necessary dental and/or medical information with other health professionals if deemed necessary for appropriate treatment.

Signature: _____ Date: _____

Child's Play Policy on Payment & Insurance

In order to prevent any misunderstanding regarding payment for treatment, please understand that as the parent are directly responsible for payment of all treatment fees at the time of service. You should understand, and be aware of your insurance coverage and its limitations. We will do our best to inform you of what your insurance company will pay for recommended treatment.

Initial: _____

Child's Play Policy on Missed and Late Appointments

In order to provide the best possible care for all of our valued dental patients, we kindly request that you provide us with a minimum of 2 business days' notice if you are unable to keep your child's appointment, so that we may better accommodate other patients. Short notice cancellations (<2 business days) or missed appointments may result in a cancellation fee. Being late for an appointment may result in rescheduling that appointment in order to best service the remainder of the patients scheduled that day.

Initial: _____

Child's Play Pediatric Dentistry Privacy Policy

Our dental office is responsible for all personal information. The policies and practices we employ for handling this information is to ensure our office complies with the provincial privacy legislation in force. For more information on our policies or, should you have any concerns, please contact our office privacy officer whose contact information will be given to you upon request. As a dental patient, or consenting parent for a child/minor patient, the personal information is requested to ensure safe and appropriate dental care. It will only be collected, used and disclosed for this purpose. Similarly, financial information will also be collected, used and disclosed for the payment of services rendered.

Initial: _____

Consent to collection and use of personal information: _____
Signature

Our mission is to be the best pediatric dental office possible. We are committed to being an enthusiastic team, working with you for your child's optimal oral health. Our patient's emotional and physical well-being is our number one priority and we will strive every day to make it fun for them as well as safe and rewarding.