# Client Registration

## Patient Information

Name: Date of Birth:

Facility Name: Room number:

## Care Decisions

Name: Relationship to Patient:

Phone number: Email:

Address: Postal code:

## Financial contact

Name: Relationship to Patient:

Phone number: Email:

Address: Postal code:

## Consent for Dental Hygiene Services

- ❑ I consent to an initial dental hygiene assessment only ($49)
- ❑ I consent to a recare assessment and cleaning incl fluoride ($100-$300 based on need)
- ❑ I would like to be notified of additional care recommendations

## Insurance

Insurance Carrier: Group Number: Individual number:

**PRIVACY:** The information collected is required to enable us to provide you with the best possible oral healthcare. All information is strictly confidential and is protected by the **Personal Information Protection and Electronic Documents act (PIPEDA).** The registered dental hygienist will explain any questions that you do not understand.

**TREATMENT/HEALTH CONSULTATION:** I understand that all necessary will be explained to me and give my consent for treatment as indicated above. I consent to allow Go Smile to access my/the patient's medical history as it may pertain to the requested services. I also authorize the release of information to third party insurance carriers, payors and to my medical doctor or other healthcare providers if necessary.

**PAYMENT:** I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependants.

**E-MAIL:** I consent to receive correspondence via email including follow up care recommendations, confirmation of appointments, reminders and information about upcoming clinics or community involvement events.

Client/Guardian Signature:_____ Date:_____