Dr Brian Clark
102-4005 27th St.
Vernon, B.C.
250-549-5205
250-549-2836

Informed Consent

Your co-operation in completing this consent form is essential to providing you with the highest standard of dental care. All information is strictly confidential and follows the guidelines of the Privacy Act. We will review your medical and dental history chairside for our electronic records.

Patient Name: _____
(First) (Last) (Initial)

Address: _____City_____Postal Code:_____

Date of Birth: _____ S.I.N.# _____
Month / Day / Year

Home Ph: _____ Cell Ph:_____ Work Ph:_____ Ext:_____

Email Address: _____

Best Contact Number: _____ I prefer contact by : ❒Text ❒Email ❒Phone

Parent/Guardian Name: (If under 18 years) _____
(First) (Last) (Initial)

Employer_____

Do you have dental insurance? ❒Yes ❒No
If so please give the information to our administrative staff.

Who can we thank for referring you to our office? _____

I, the undersigned, certify that I have provided an accurate and complete personal and medical/dental history. I understand that providing incorrect information can be dangerous to my health. Should there be any change in my health status in the future, I will advise this dental office. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I authorize the dentist to release any information, including the diagnosis and records of any treatment rendered to me or my dependents during the period of such dental care to third party payers and/or other health practitioners. I consent to photographs being taken to evaluate treatment effectiveness, for medical education, training, professional publications. No photographs revealing my identity will be used without my written consent. I understand that the responsibility for payment of the dental services for myself and my dependents are mine and due and payable at the time of service.

X_____ _____ _____
Signature of Patient/Parent/Guardian Print Name Date