GENERAL/ PIPEDA RELEASE

It is important that any change in your health status be reported to our office.

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 have had an opportunity to ask questions and receive answers to any questions regarding my medical - dental history. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that the information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

GOVERNING LAW

The patient agrees that the relationship between himself or herself and the dentist shall be governed and construed in accordance with the laws of the province of Ontario.

Patient Parent Guardian_____Guardian Name_____

Reviewed by treating Dentist _____Date_____

Medical History Reviewed_____Date_____Initials_____

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