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INFORMED CONSENT

I authorize the Dental Personnel at Red River Dental (Dentists, Hygienists, Assistants or others appointed by the doctors) to perform services for prevention and treatment of dental disease using the procedures and medications required, and assume responsibility for the fees associated with those procedures. Treatment, costs, risks, benefits, consequences and alternatives will be discussed based on my current oral needs and I understand this may change frequently. I authorize and consent to Red River Dental Group to release copies of my dental records from my previous or current providers as requested by third parties.

Red River Dental is committed to protecting your privacy in accordance by the guidelines set by PIPEDA (Personal Information Protection and Electronic Documents Act).

This authorization and consent shall be valid until withdrawn by me, in writing.

Signature of patient or parent _____ Date _____

Due to the potential of exposure to blood and body fluids from injuries, lacerations (needle-poke) and exposed membranes, staff exposure to these potential events will have to be treated as a medical emergency. In the event that there was an occurrence, it is our policy to have patients be tested for Hepatitis B, C, and HIV at the hospital or a medical office as soon as possible.

Patient/Guardian Signature _____ Date _____