Consent to Treatment

The dental and medical profiles I have provided are complete and accurate. I request the dentist and all qualified employees of Warmland Dental to perform assessment and diagnostic procedures for the purpose of determining my oral health condition and recommending appropriate treatment options.

I understand that I have the right to:

- be advised of the benefits, options and risks of any dental procedure
- ask questions and receive complete answers regarding my oral health
- make an informed decision to accept or decline recommended treatment

I have read the document supplied to me titled 'Office Policies' and understand its contents. I have had sufficient time and opportunity to read the document in full and ask for clarification.

I understand that I am to pay my entire portion at the time of treatment unless other arrangements have been made in writing. I authorize Dr. Tom Roozendaal Inc. to send information requests including pre-authorizations for any treatment to my dental insurance provider. I understand that if the insurance information provided to Dr. Tom Roozendaal Inc. is incorrect or out of date that I am responsible for any outstanding balances in full. I understand that estimates given are valid for a period of six months.

I understand that a $75 fee will be charged to me if I do not give a minimum of 2 business days (48 hours) notice to change or cancel an appointment. I am familiar with the office hours of Dr. Tom Roozendaal Inc. and that these hours indicate the business days.

I understand that the information gathered on this form and in subsequent visits may be used to contact me and to discuss matters related to my care with other healthcare providers who may participate in my care. I authorize the use of my radiographs (x-rays), digital photos and clinical findings (chart notes) for educational purposes or presentations while guaranteeing my anonymity. I understand that my personal information will not be given to anyone for any other purpose.

☐ I have read the above Consent to Treatment and agree to its content in full.

Signature of Patient, Parent or Guardian: _____

Date Signed: _____ Relationship to Patient: _____

dd/mm/yyyy