First Nations Health Authority
Health through wellness

Community Dental Clinic Consent Form

NAME OF CLIENT

DATE OF BIRTH: DATE_____/ MONTH_____/ YEAR _____

STATUS NUMBER BC HEALTH CARE CARD NUMBER

I understand that treatment will be provided by an FNHA oral health professional. Where treatment is provided by an FNHA dental therapist or dental hygienist, I understand that the examination, x-rays and any required treatment will be provided to me at no cost.

_____ CLIENT INITIALS / PROXY

If required, your health information, dental treatment history and x-rays will be provided to the dentist or specialist via email, which is deemed as an only available means for transmission. As such, I understand that email is not entirely secure with potential risk of interception or security breach, albeit highly unlikely.

_____ CLIENT INITIALS / PROXY

I understand that I am required to attend appointments as scheduled. In the event that I am unable to attend, I will contact the **health center/provider no later than 24 hours before my scheduled appointment so that my time can be offered to another** community member.

_____ CLIENT INITIALS / PROXY

When care is provided by a dental therapist, I understand that my health information, dental x-rays and examination results will be shared with the FNHA supervising dentist to review and approve my treatment plan prior to proceeding. I understand that all proposed treatment will be explained to me and I will have the opportunity to ask questions and have them answered to my understanding before consenting to any dental treatment. _____ CLIENT INITIALS / PROXY

Any treatment I require that is beyond the scope of the dental therapist will require a referral. Where possible, FNHA can provide you with a list of providers, if needed. I understand that where treatment is provided by an external provider, there may be a **cost associated with it which may or may not be covered by the FNHA Benefits Program.**

_____ CLIENT INITIALS / PROXY

I understand that **all** personal information is protected under the *Personal Information Protection Act* of BC and that the information I have provided will only be used or disclosed for the purposes of providing dental care. Accordingly, my records may be shared with physicians, dentists, oral surgeons, specialists, and other health professionals as necessary for the purposes of continuity of care.

I,_____confirm that I have read and understood the content of this authorization form, and hereby consent to be a client of this community clinic.

Complete if applicable:

I am the proxy for_____, and hereby consent on his or her behalf.

(If used) PROXY FULL NAME and relationship to client (please print): _____

Client/Proxy Signature: _____ Date: _____
DD / MM / YY

Clinicians Initials: _____