Green Road Dental Personal Information Consent Form

We are committed to protecting the privacy of our patients’ personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. This office follows PIPEDA or the Personal Information Protection and Electronic Documents act. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, telephone numbers, work numbers, and email addresses. (collectively referred to as “contact information”). Contact Information is collected and uses for the following purposes:

* To open and update patient files
* To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts.
* To process claims for payments or reimbursement from third-party health benefit providers and insurance companies
* To send reminders to patients concerning the need for further dental examinations or treatments.
* To send patients informational material about our dental practice.

Contact information is disclosed to third party health benefit providers and insurance companies where the patient has submitted claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient’s behalf.

Financial information may be collected in order to make arrangement for payment of dental services.

We collect information from our patients about their health, their family health history, physical condition and dental treatment. (Collectively referred to as “Medical Information”) Patients’ Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients’ Medical Information is disclosed:

* To the third-party health benefits providers and insurance companies where the patient had submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient’s behalf.
* To another dentist or dental specialists, where we are seeking a second opinion and the patient has consented to us obtaining the second opinion.
* To other dentist or dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment.
* To other dentists and dental specialist where those dentists have asked us, with the consent of the patient, to provide a second opinion.
* To other health care professional for second opinion or treatment.

By signing the consent section of this Patient Consent Form, you have agreed that you have given your information consent to the collection, use and/or disclosure of your personal information for the purpose arises for use the use and/or disclosure of your personal information, we will seek you approval in advance.

I have reviewed the above information that explains how our office will use my personal information, and the steps your office is taking protect my information.

I know that your office has a Privacy Code, and I can ask to see the code at any time.

I agree that *Dr. Sri Mohan Rajagopalan* can collect, use and disclose personal information about (print name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as set out above in the information about he office privacy policies.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Green Road Dental*

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