Saskatchewan Health Authority

Resident Label

NAME: _____

HSN: _____

D.O.B.: _____

LONG TERM CARE
ORAL HEALTH PROGRAM
HOME: _____

ANNUAL DENTAL EXAMINATION CONSENT

Resident's name: _____ **Room #:** _____

I, _____, hereby authorize a dentist who is working with the program to perform an annual examination.

In requesting this examination, I recognize the dentist accepts my right to choose the treatment of my choice following consideration of the treatment plan provided to me.

I fully understand:

- An annual examination prior to receiving dental treatment from other oral health professionals, employed by the dentist, is mandatory. This is important to prevent, diagnose, and minimize conditions which may result in complications associated with dental treatment.
- All findings of the examination will be provided to each resident as a treatment plan. The written plan will be presented to the resident and/or care provider. This will include the treatment plan, a fee estimate for the dental treatment, and consent to proceed with the proposed treatment.
- A prescription for mild oral sedation may be required prior to dental treatment. If necessary, I consent to the physician providing a sedation prescription.
- There is a charge for the dental examination, as outlined in the *College of Dental Surgeons of Saskatchewan* current fee guide.

The collection of health and dental information is consistent with the requirements of our profession and those of the *Health Information Protection Act of Saskatchewan* and the *Personal Information Protection and Electronic Documents Act of Canada*. We acknowledge our duty and responsibility to hold in confidence your personal health information gathered in the course of our professional relationship. I understand it is my responsibility to pay for dental treatment. I understand that if I have provided an email address that correspondence may occur through email.

If you have any questions about these services, or if you have limitations, possible complications, or other information, contact the Long Term Care Oral Health Coordinator at **(306) 655-4317**.

_____
Name of the authorizing person

_____
Address and postal code of authorizing person

_____
Home phone #/Cell phone #/Work phone #

_____
Authorizing person's signature

Return this form to:

_____

_____

_____

_____
Relationship to resident

_____
Email address of authorizing person

Dental benefits/Insurance: ❑ Yes ❑ No

Name of insurance plan: _____

Group plan number: _____

Name of subscriber: _____

Certificate/ID # of subscriber: _____

Date of birth (subscriber): _____

Date of birth (spouse): _____