

Dr. Diya Chadha DMD, FRCD(C)  
Certified Specialist in Pediatric Dentistry

Dr. Karim Kanani DMD  
Certificate in Pediatric Dentistry



Unit 110, 20780 Willoughby Town Centre Dr  
Langley, BC V2Y 0M7  
P: (604) 371-2830  
F: (604) 371-2831  
office@smiletownlangley.com  
www.smiletownlangley.com

## **Consent for Treatment and Office Policies**

### **Parent (Guardian) Consent For Minors (<19 Years Old)**

I, the undersigned, consent to the doctors of SmileTown Dentistry, assisted by their dental staff, to perform an examination and dental and/or oral surgery procedures deemed to be necessary or advisable, including, but not limited to, the taking of radiographs (dental x-rays), use of diagnostic aids, extractions (removal of teeth), and use of local anesthesia on my child. I also consent to the release of any necessary dental and/or medical information with other health professionals if deemed necessary for appropriate treatment. I will assume responsibility for fees associated with these procedures and understand that fees are due at the time of service.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Policy on Missed and Late Appointments**

In order to provide the best possible care for all of our valued dental patients, we kindly ask that you give us a minimum of 48 business hours notice if you are unable to keep your child's appointment, so that we may better accommodate other patients. Short notice cancellations (<48 hours) or missed appointments may result in a cancellation fee. Being late for an appointment may result in rescheduling that appointment in order to best serve the remainder of the patients scheduled that day.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Privacy Policy**

Our dental office is responsible for all personal information under the policies and practices we employ for handling this information to ensure our office complies with the provincial privacy legislation in force. For more information on our policies or, should you have any concerns, please do not hesitate to ask. As a dental patient, or consenting parent for a child/minor patient, personal information is requested to ensure safe and appropriate dental care. It will only be collected, used and disclosed for this purpose. Similarly, financial information will also be collected, used and disclosed for the payment of services rendered. Please sign below for the consent to collect and use personal information.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Our mission is to be the best pediatric dental office possible. We are committed to being an enthusiastic team, working with you for your child's optimal oral health. Our patient's emotional and physical well-being is our number one priority and we will strive everyday to make it fun for them as well as safe and rewarding.