

ER Dental Group – Your Information & Consent

Why we ask for this

We collect and use your personal and health information so we can look after your dental care properly. This form explains what we do with your information and asks for your permission.

Who we are

ER Dental Group clinics work together, but each clinic is a separate business. Sometimes we need to share information within the group to make sure you get the right care.

What information we collect

We may collect:

- Your name and contact details
- Your medical and dental history
- X-rays, photos, treatment notes, and test results
- Billing and payment information

Why we use your information

We use your information to:

- Provide dental treatment and follow-up care
- Manage appointments, billing, and administration
- Check quality and improve our services
- Meet legal and professional requirements

Sharing your information within ER Dental Group

I understand and agree that my information may be shared between ER Dental Group clinics when needed for:

- My treatment and continuity of care
- Moving between clinics within the group
- Practice administration and clinical oversight

Only the minimum information needed will be shared.

Sharing outside ER Dental Group

Sometimes we may need to share information with others, for example:

- Dental specialists or labs involved in my care
- ACC or insurance providers
- Where the law requires it

We will not use my information to market other clinics or services unless I agree.

Keeping your information safe

We take steps to keep your information secure and only accessible by authorised staff. Some systems may be cloud-based. If information is stored overseas, it is protected under New Zealand privacy laws.

Your rights

You can:

- Ask to see your information
- Ask for corrections
- Withdraw this consent (this may affect care)
- Make a privacy complaint if concerned

Consent

I have read and understood this information. I agree to how ER Dental Group uses and shares my information as explained above.

Patient Name: _____

Date of Birth: _____

Signature: _____

Date: _____

If signing for a child or someone unable to consent:

Parent / Guardian Name: _____

Relationship: _____

Signature: _____

Date: _____