THE PRINCE PHILIP DENTAL HOSPITAL
Teaching Patient's Declaration Form

In connection with the initial examination and subsequent treatments / consultation (if any) at The Prince Philip Dental Hospital (the Hospital) of **myself/ my child/ the person concerned***

(*Name in BLOCK letter:*_____*Identification Document No.:*_____),

I hereby declare (on behalf of my child / the person concerned) that:

1. I have read, fully understood and agree to comply with all terms and conditions set out in the "Notice to Members of Public who Intend to Seek Dental Treatment from the Hospital (version dated 17.07.2019)" and "Statement of Collection of Personal Information from Patients";
2. I hereby consent to and authorise the Hospital or University of Hong Kong to use all or any anonymized photographs, radiographs, scan images or study models taken of me/ my child/ the person concerned, for the purposes of education, research records and /or publication;

Functions of the Hospital

3. I understand that the Hospital is a teaching hospital, and will not provide public dental services. All treatments of teaching patients are wholly geared to the training of undergraduate students of Faculty of Dentistry of The University of Hong Kong (the Faculty), dental ancillary students, or staff of the Faculty/the Hospital;

Initial Examination Process

4. I/ My child/ The person concerned agree(s) to be examined in the course of a screening process. I understand that the Hospital will not provide any dental treatment or follow-up if I / my child/ the person concerned have/ has not been accepted as a teaching case after examination. In that case, I will accept without any claim against the Hospital that I/ my child/ the person concerned shall have to seek further dental or medical attention or treatment elsewhere;
5. I understand that waiting time for the screening and examination process may vary, and that there is no guarantee that admission as teaching patient would be offered to me / my child / the person concerned. I understand that, during the period of the screening and examination process and before I / my child / the person concerned am / is accepted as a teaching patient, the Hospital will not provide any dental treatment or follow-up. Should any symptom or health condition arise during such period, I / my child / the person concerned should promptly seek dental or medical attention or treatment elsewhere in order to avoid any health risk resulting from delay in seeking treatment
6. I am aware that the initial examination is likely to be time-consuming and will usually require a whole morning or afternoon session;

Subsequent Treatment/ Consultation Arrangements (if any)

7. If I am/ my child/ the person concerned is accepted as a teaching patient, I understand and accept that the waiting time will depend on the needs of the relevant teaching programmes and the nature and type of the dental problems, varying from several weeks to several years, and that during such waiting period I / my child/ the person concerned should immediately seek dental or medical attention or treatment elsewhere in the event of any changes in the condition or symptoms to avoid any health risk resulting from delay in seeking treatment from the Hospital;
8. I understand that in view of the teaching requirements, each appointment for treatment/ consultation is likely to be time-consuming and will usually require a whole morning or afternoon session;
9. I understand that the Hospital has the absolute right to cease further treatment or follow-up if the Hospital considers that the dental problems of me/ my child/ the person concerned are no longer suitable for teaching purposes or for further examination by various clinics of the Hospital. In that case, I understand that the Hospital will issue a letter of referral upon request for me/ my child/ the person concerned to seek further treatment elsewhere and I accept such arrangements without any claim against the Hospital;
10. I accept without any claim against the Hospital that the Hospital has the absolute discretion to discharge me/ my child/ the person concerned from the care and attention provided at the Hospital for reasons such as failure to attend a scheduled appointment on time twice, absence without giving one working day's prior notice, refusal to receive further treatment, failure to be contacted, failure to follow the treatment schedule, non-compliance with the recommended treatment plan/ dental advice, committing any nuisance in the Hospital, failure to comply with any term or condition set out in the "Notice to Members of Public Who Intend to Seek Dental Treatment from the Hospital", or having unreasonable expectations, etc. I understand that the reasons stated are not exhaustive, and the ultimate decision to discharge a patient rests with the Hospital;
11. I understand that in the case of emergency, the Hospital may advise me/ my child/ the person concerned to seek further dental or medical attention or treatment elsewhere, which I will accept without any claim against the Hospital;
12. I understand that I/ my child/ the person concerned have/ has to use the dental consumables, dental appliances or dental materials provided by the Hospital, and I shall have no claim against the Hospital due to any loss and damage arising from the inherent defects of such materials;

Fees and Charges

13. I understand that there is no refund of Attendance Fee even if I/ my child/ the person concerned am/ is not accepted as a teaching case or if I/ my child/ the person concerned am/ is discharged by the Hospital;
14. I agree to pay the fees and charges of the Hospital as prescribed in the Schedule of Fees which I understand may vary from time to time. I accept without any claim against the Hospital, that if I fail to settle the fees within the specified period, the Hospital has the absolute right to discharge me/ my child/ the person concerned from the care and attention provided at the Hospital; and
15. I understand that I should not accept any demand notes or receipts issued by individual staff of the Hospital/ the Faculty outside the invoicing system of the Hospital; and that all the Hospital fees and charges must be paid to the Hospital's Shroff Office (1/F) directly, but not to any other staff.

[If you are signing for the patient, please give details: (i) Name in BLOCK letter: _____*;*

*(ii) Identification Document No.:*_____*; (iii) Relationship with patient:*_____*]*

_____ _____
Signature of **patient/ guardian*** Date

Original: Patient Record
**Delete as appropriate*
PPDH 330A (Rev. 7.2019)