

The Temple Practice, Dental Consent form

PLEASE ANSWER ALL THE FORM OR IT WILL BE RETURNED.

Patients Name requiring visit:

Name of Care Home if applicable:

Address of patient:

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Patients D-O-B:

Reason for dental visit: e.g._New dentures, exam or

Problem?

Please ensure a medical history form has been completed for each patient and given to the dentist on his arrival or sent back with consent form.

Do you pay for NHS Dental Treatment? Yes/No

****If Yes we require £21.60 at the first check up which covers the NHS exam charge. ****

Payments must be made on the day of visits, if payment is not made visit may be declined!

If **NO** please give details of exemption e.g.: Income Support, Pension Credit Guaranteed Credit or have an HC2 exemption certificate (please give certificate number and valid to and from date)

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Full name of person giving consent for Dental visit/ treatment e.g.: power of attorney

Name:

Billing Address:

.....

Contact Telephone number:

I named above give full consent for Mr G Temple to examine and provide Dental treatment when necessary.

Signature:

Date:

Relationship to patient:

Please note that if you no longer require our services for your relative, please contact us on 0113 2680886 to cancel this arrangement **The Temple Practice, 375-377 Harrogate Road, Leeds, LS17 6DW**