temple dental
home care

CONSENT TO DENTAL TREATMENT

PLEASE ANSWER ALL QUESTIONS ON THE FORM OR IT MAY BE RETURNED

Patients name requiring visit: .....

Name of care home (If applicable): .....

Address of patient: .....

Patients date of birth: ...../...../.....

Reason for dental visit eg new dentures; examination etc:

.....

Please ensure a medical history form has been completed for each patient and given to the dentist on arrival or sent back with consent form. Please note - we require a payment of **£90** before we are able to arrange an appointment.

You can make payment by card over the phone, by cheque payable to Leeds Dental Team Ltd, or you can make a bank transfer to:

Leeds Dental Team Ltd

Sort code: 53-61-07

Account number: 70394288

Please remember to quote the name of the patient the payment is related to as a pay reference.

If further treatment is required you will be given a quote, and payment will be required at the next visit

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

.....

Billing address: .....

Contact telephone number:

.....

I, named above, give full consent for Mr G Temple to examine and provide dental treatment

Signature: .....

Date: ...../...../.....

Relationship to patient:

.....

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