



The Hub Dental Practice



Love Your Smile

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Dr David Gilmartin,
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Dr Etienne Deysel, Sedationist

Dr Aaron Lopez, Specialist Periodontist
Dr Monica Cueva Moya, SI Periodontics
Dr Gulelala Azhar, SI Restorative,
Dr Giovanni Marras, PLT Periodontics
Miss Sam Singleton, Practice Manager
Mrs. Nur Gilmartin, Dental Hygienist

Dr Alvaro De Castro Torres, SI Dental Implants & RCT
Dr Konstantinos Tzamalass, Specialist Orthodontist
Dr Iyad Abou-Rabii, PLT Dental Implants & Oral Surgery
Dr Ezgi Cilingir, PLT Dental Implants & Periodontics
Dr Jonathan Harper, PLT Endodontics
Dr Jaime De Castro Torres, SI Dental Implants

Consent form for Retainer/Splint

I acknowledge that I am only having a Retainer/Splint made at the practice.

I certify that I have been advised to see a Dentist prior to having a retainer/splint made.

I acknowledge that I am have been told that I need to make an appointment to see an ORTHODONTIST within 1 month to review the retainer and the state of my dentition/occlusion.

The dentist that examined me has fully explained to me the purpose of the procedure(s) and has also informed me of the expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the purposed treatment, including no treatment.

The attendant risks of no treatment have also been discussed.

I certify that the dentist who examined me that the success of all treatment is determined in a big way by following post treatment instructions, and that these are always given to patients after treatment, both verbally and in writing, and it is essential that patients read and keep them. Please make sure you have them and do not be afraid to ask for them!!!

I have been given an opportunity to ask questions and all my questions have been answered fully and satisfactorily.

I have been give the opportunity to delay my decision/treatment and/or seek a second opinion

I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedure(s) which the above named dentist or his/her associates may consider necessary.

I acknowledge that no guarantees or assurances have been made to me about how long the retainer/splint will last and that if it breaks or is damaged or otherwise does not fit there will be a charge made for a replacement.

I also understand the financial obligation attached to this procedure carried out today and agree to comply as listed below.

Total amount due £.....

I understand that I am responsible for all fees. I also understand that as treatment progresses the above fees may have to be adjusted, but that I will be informed of these adjustments and how will affect my payment plan.

I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing.

I realise that signing does not mean that I am under an obligation to have any treatment and that I may decide not to proceed with all or any part of the treatment. Similarly signing this means that I only pay for the treatment that I have actually had done.

I hereby consent to the proposed dental treatment acknowledge that it is being provided as a **Private Patient**.

Name _____

Date of Birth ____//____//____

Signature _____

Date ____//____//____