The Hub Dental Practice
Consent Form for LASER TREATMENT

I hereby authorise the dentist at The Hub Dental Practice to carry out the following treatment with the use of the Apex Laser.

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I certify that I have not been advised not to have laser treatment by my doctor, previous dentist or any medical practitioner.

I certify that I have been told the importance of wearing the Eye Protection during the whole of the procedure.

I certify that the dentist who examined me has fully explained to me, verbally and with leaflets, 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.

I certify that the dentist who examined me has discussed my treatment plan verbally as well as giving me leaflets and other printed literature related to the treatment that is proposed as well as the alternative options.

I certify that the dentist who examined me has explained the attendant risks of no treatment.

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, especially those that relate to anaesthetics and prescription medications, 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 certify that I have been given an opportunity to ask questions and all my questions have been answered fully and satisfactorily.

I acknowledge that **no guarantees or assurances** have been made to me concerning the results intended from the procedure(s) which the dentist may consider necessary.

I also understand the financial obligation attached to this procedure 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 this will affect my payment plan.

I realize 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 pay for the treatment that I actually have done. I hereby consent to the proposed dental treatment and acknowledge that it is being provided as a private patient.

(CF Laser Treatment)

Name of Patient : _____ Date of Birth-: _____

Signature : _____ Date : _____