

Consent Form

Facility Details

Facility Name: _____ Phone: _____

Facility Address: _____

Patient Details

Title: _____ DOB: _____ / _____ / _____

First Name: _____ Surname: _____

Authorized Consentee Details

Title: _____ Relationship: _____

First Name: _____ Surname: _____

Address: _____

Phone: _____ Email: _____

I hereby consent to Alpha Dental providing the nominated service/s to the patient mentioned above. I acknowledge that I am financially for the cost involved in providing dental treatment.

Signature: _____ Date: _____ / _____ / _____

Should further treatment be recommended by the Dentist, a detailed quote will be forwarded to you for approval. Prosthetics (Dentures) will require 50% of total cost to be prepaid before denture manufacture can commence.

Verbal/ Phone Consent

Date: _____ / _____ / _____ Time: _____ Staff Name: _____

Staff Signature: _____

GP Details

GP Name: _____

Clinic Name: _____

Phone: _____

Fax: _____

Patient Medical History:

(please list or supply a photocopy of CMA)

Allergies:

Dental Services

Comprehensive Exam & Clean \$280.00

Service fee; comprehensive oral examination including oral hygiene instructions (care plan), scale, clean, and fluoride.
To prevent repeat visits (which may incur a separate attendance fee), if required I consent to the following being undertaken

X-Rays \$47.00 Fillings (POA) Extractions \$163.00

Ongoing Maintenance of Oral & Dental Health

3 Monthly 6 Monthly 12 Monthly

* the average person should have a scale and clean at least once every 6-12 months.
For older adults who have difficulty with oral hygiene (e.g. twice daily brushing with good technique) the recommended frequency is 3-monthly

Denture Services

Denture Examination Only \$80.00

Includes: Assessment of gum health and review of denture fit.

Payment Details

Please select if applicable:

DVA Gold Car Holder

Card No: _____

Trustee (e.g. State Trustee)

Trustee Name: _____

Ref No: _____

Credit Card Details – Payment for treatment is by pre-approved credit care authority

VISA

MasterCard

Card no: _____

Expiry: _____ / _____