CONSENT FOR SERVICES:

Please tick boxes to acknowledge

- ☐ I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic and other medication as indicated and I will assume responsibility for the fees associated with those procedures.
- ☐ I understand that the practice requires at least **24 hours' notice** if I need to cancel my appointment. I understand a fee of $50 may be applied if I do not attend my appointment or cancel within the 24-hour period before my appointment.
- ☐ I understand failure to respond to the confirmation texts or phone calls sent by Dental on Errard may result in an automatic cancellation of my appointment. **I understand confirmation is required for my dental appointment to go ahead.**
- ☐ I hereby authorize the dentist or the designated team to take x-rays, photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.
- ☐ I am aware that payment is required **on the day of treatment.**

Signature: _____

Date: _____