CHILD'S HOSPITAL TREATMENT CONSENT / BOOKING FORM

WE REQUIRE THIS FORM TO BE RETURNED TO THE PRACTICE TO PROCEED WITH TREATMENT

Please sign and return to Kiddies Dental Care by Email: hospitalcare@kiddiesdentalcare.com.au.
Post: Hospital Bookings, Kiddies Dental Care Suite 2, 127- 131 Napier St, ESSENDON, Vic 3040.

Child's Name .....

Child's Date of Birth .....

Proposed Date .....

Proposed Theatre Location Please select

I confirm that:

1. I am Please select of (patient name) .....
2. The Dentist has clearly explained the nature of the treatment as per the proposed treatment plan and treatment information sheets provided, its purpose/s, approximate costs, risk/s, side effects, possible complications, expected longevity, maintenance requirements and alternative/s to me.
3. I have been given the opportunity to ask questions about the proposed treatment and all questions that I have asked have been answered to my satisfaction. I understand that should any change in the treatment plan be required, it will be explained to me and my specific consent obtained.
4. I have been given sufficient time to understand, consider and consent to this treatment.

Signature ..... Date .....

Parent's/ Legal Guardian Full Name .....

Are there any court orders / custody arrangements / parenting orders for the child (please circle) YES ◯ NO ◯

IF YES TO ABOVE Is there anything in these orders that will affect your ability to provide consent for treatment. If yes please provide us a copy of the current court order for your child. (please circle) YES ◯ NO ◯

CONSENT FOR DEPOSIT TO SECURE TREATMENT BOOKING

I authorise Kiddies Dental Care to obtain a $200 non-refundable deposit and proceed with a General Anaesthetic Treatment Booking as detailed above. I understand

1. Kiddies Dental Care will confirm this booking via email once deposit has been processed
2. Kiddies Dental will contact me if location and date requested is no longer available prior to processing deposit to discuss alternative date.
3. Once treatment time has been confirmed by all parties a confirmation email will be sent. Please follow links to complete the relevant paperwork, complete NO LATER than 10 days prior to treatment date.
4. The balance of treatment as per the treatment plan provided must be 7- 10 days before the treatment date or cancellation will occur

PLEASE DEBIT THE AMOUNT OF $200 FROM MY CREDIT CARD DETAILS BELOW

VISA / MASTERCARD Credit Card Number ..... EXPIRY ..... / ..... CVC .....

Cardholder's Name .....

Please debit the card details above for the final payment due 7-10 days prior to the day of treatment by Kiddies Dental Care

NO ◯ YES ◯ Amount to be debited $ ..... Phone No .....

Signature .....