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Date : \_\_\_\_\_

I \_\_\_\_\_ have been advised by my dentist to have a comprehensive oral examination for my complete dental care.

I have decided against this examination at this time and I understand that this decision is my choice and releases my treating dentist and Glen Forrest Dental Care from any liability that may arise from this decision.

I understand that this decision may compromise my dental health and treatment.

I also understand that I am able to withdraw this decision at any time I choose to.

Name: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

**Disclaimer:** The oral cavity is a changing and active biological environment and things can occur without notice. During the preventive procedure, defective or loose fillings may fracture or become dislodged. The practice cannot be held responsible if this occurs as we have not received permission to completely examine your mouth prior to this preventive care procedure.