

Appendix 4

Patient Consent Form

I, Katherine Andrews - Liubovnik accept and acknowledge that the information regarding my treatment with Dental Implant Restoration by Dr. Shyam Bhat have been released with my full approval.

I also accept being contacted by the Department of Health of Abu Dhabi with regards to my implant case for the purpose of examination of the professional.

I have no objection to have my records audited by DOH inspection team for whatever purpose it may require.

Patient Full Name: Katherine Andrews - Liubovnik

Signature: [Handwritten Signature]

Date: 15/03/23