

Dental Treatment Consent Form

Patient Name:_

| 1. <i>Health Information</i> : I agree to disclose all pand current medications allergies or illnesses | = | medical history. Undisclosed medical information |
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| be life threatening and can sometimes interfe | ere with birth control p | ther medicines can cause allergic reactions that can pills and /or other medications. Latex allergies can beat and depending on my health can be dangerous |
| 3. <i>Needle Stick:</i> If someone is inadvertently analysis. | stuck with a needle us | sed on me I consent to have my blood drawn for |
| 4. <i>Limitations of Insurance Coverage:</i> WE ARE AN IN-Network Provider for most PPOs Fortunately, this will save you money! You will receive a discount off our regular fees because you are entitled to a LOWER in-network fee Your insurance carrier and your employer have set up your coverage and in-network fees for you. Unfortunately, your insurance will not always pay 100%. In fact most insurance companies pay between 80-50% for fillings and crowns There are also charges beyond what insurance will pay, i.e. nitrous oxide, cosmetic work and other misc fees. After your exam, you will be provided with a treatment plan that explains your expected costs for any treatment needed You will be given the opportunity to ask questions about your coverage at that time. | | |
| | ble for the portions of | esy to me and that any qu <mark>ote for my p</mark> ortion is only payment that my insurance company does not pay dures. |
| 2 4 | and daily home care. | and dental work r <mark>equire upkeep, i</mark> ncluding but not If I experience discomfort with my new dental work, ly manner. |
| I have read the above and consent to treatmen | et." | |
| Signature of Patient or Parent of Minor | Date | Witness |
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