A FAMILY DENTAL CARE
WELCOME TO OUR OFFICE

We would like to thank you for choosing our office for your dental care. It is our objective to make your visit as pleasant as possible and provide you with quality dental care.

HEALTH HISTORY
All patients or parents of minor patients will be asked to complete a health history record.

EXAMINATION
Diagnostic x-rays will be taken and developed immediately. The Dentist will examine the teeth and surrounding tissues. Treatment of the case will be discussed.

FEES

1. There will be an examination fee charged.
2. Fees vary with the complexity or difficulty of treatment.
3. Fees are quoted in advance of treatment.
4. Fees, once quoted, remain the same unless treatment is delayed (at the request of the patient) for a long period of time, or your insurance changes.
5. **There is a $35 fee for Broken Appointments.**

METHOD OF PAYMENT
Payment is due at the time of treatment. If you have an Indemnity or PPO insurance plan, and benefits are confirmed and/or pre-authorized prior to treatment, the difference between the estimated amount and the dental fee paid by your insurance will be due at the time of treatment Any balance left unpaid by the insurance company is the full and immediate responsibility of the patient.

CONSENT AND INFORMATION FORM

It is our belief in this office that you should be informed about the treatment and you should give your consent before staning treatment. The purpose of this form is to tell of the risk that may occur in the dental treatment and explain our office policy.

RISK OF DENTAL PROCEDURES IN GENERAL
Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth. Thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues, referred pain to the ear, neck and head, nausea, vomiting, allergic reaction, itching, bruises, delayed healing, sinus complications and further surgery. Medications and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device or work for twenty - four hours or until recovered from their effects.

ALTERNATIVE TREATMENT CHOICES
They will be discussed with you when possible. They may include: no treatment, waiting for more definite development of symptoms, or having the tooth removed. Treatment will be done in a manner to minimize or avoid risks, as success cannot be guaranteed

I understand that upon completion of my treatment I will be advised to return every 3-6 months for preventive care. I, the undersigned, being the patient (parent or guardian of a minor patient) consent to the performing of the procedures decided upon to be necessary or advisable in the opinion of the Dentist.

DUE TO OSHA REGULATIONS, ONLY THE PATIENT 'S ARE ALLOWED IN THE TREATMENT AREA. PARENT'S SHOULD REMAIN IN THE WAITING AREA UNTIL THEY ARE CALLED. CHILDREN WILL NOT BE LEFT IN THE WAITING AREA WITHOUT AN ADULT. THIS IS FOR THE SAFETY OF PATIENT'S AND STAFF.

PATIENT NAME (PRINT)_____ DATE_____