Office Policy

Cancellations and Missed Appointments

Your appointment time is reserved specifically for you and for you only. We request at least 24 hours advance notice if you will not be able to make your appointment. Repeated missed appointments or late cancellations may result in a fee of $55 per missed appointment or dismissal as a patient.

Payment

Acceptable forms of payment include cash, check, Visa, Master Card, American Express, Discover, and assigned insurance benefits. Dental insurance is a contract between you and the insurance carrier, and not between the insurance carrier and the doctor and you are still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. You assign all insurance benefits to the doctor. Any payments received by the doctor from your insurance coverage will be credited to your account, or refunded to you if you have paid the dental fees incurred.

General Informed Consent

Examinations and X-rays

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan. I authorize the doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

Changes in Treatment

I understand that during treatment, it may be necessary to change or add procedures due to conditions found while working on teeth, the most common being increasing the number of surfaces for a filling on a tooth with decay. I give my permission to the dentist to make these changes as necessary.

Drugs, Medication, and Sedation

I understand that antibiotics, analgesics, and other medications can cause allergic reactions such as redness, swelling, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. In the event that my doctor prescribes an oral sedative prior to dental treatment, I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the medication given to me for my treatment. I understand that failure to take medications as prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance that will affect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives. I understand the use of anesthetic agents embodies a certain risk.

Temporomandibular Joint Dysfunctions

I understand that symptoms of popping, clicking, locking, and pain can intensify or develop in the jaw joint subsequent to routine dental treatment wherein the mouth is held in the open position. Symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need of treatment arise, that I will be referred to a specialist for treatment, the cost of which is my responsibility.

Patient or Guardian Signature: I have read and understand the information provided above.

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Signature of Patient/Guardian Date