

TREATMENT ESTIMATE FOR \_\_\_\_\_ DATE \_\_\_\_\_ ACCT.# \_\_\_\_\_  
 DENTIST \_\_\_\_\_ INSURANCE\*/DENTAL PROGRAM \_\_\_\_\_

**FINANCIAL ARRANGEMENTS**

I consent to and authorize the indicated dental services to be performed. I understand that at any time I may terminate or postpone such treatment. I agree to pay the fees for dental treatment as indicated:

- Payment in full at each appointment (cash or personal check)
- Payment in full at each appointment ( MC  VISA)
- # \_\_\_\_\_  
Exp. Date \_\_\_\_\_
- Payment in accordance with Dental Office's financial policy

**SERVICE CHARGE**

If I do not pay the entire new balance within \_\_\_\_\_ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of \_\_\_\_\_% per month (or a minimum charge of \$ \_\_\_\_\_ for a balance under \$ \_\_\_\_\_) which is an annual percentage rate of \_\_\_\_\_% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

**DENTAL INSURANCE\***

I understand that my dental insurance is a contract between the insurance carrier and me and not between the insurance carrier and the dentist; therefore, I am still responsible for all dental fees. I understand that I will be charged for all dental treatment and that any payments received by the Dental Office from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees incurred.

**INFORMED CONSENT**

I have been informed of my dental ailments, treatment options, benefits, substantial risks and consequences of limited or non-treatment.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

	TREATMENT RECOMMENDATIONS	FEE SCHEDULE	INSURANCE/ ALTERNATE COVERAGE	ADJUSTMENTS	PATIENT PORTION/ COPAYMENTS
Examinations, X-Rays, Tests, and Preventive Services	Oral Examination				
	X-Rays				
	Diagnostic Casts/Photographs				
	Prophylaxis (Routine Cleaning)				
	Fluoride				
	Disease Prevention Program (OHI)				
	Sealants				
Periodontal Treatment	Debridement Prior to Exam				
	Palliative (Emergency) Perio Trmt				
	Root Planing and Scaling (Perio)				
	Re-Evaluation of Perio Therapy				
	Periodontal Maintenance (SPT)				
	Desensitizing Medicament				
	Soft Tissue Surgery				
	Osseous (Bone) Surgery				
	Occlusal Adjustment				
	Localized Therapeutic Medicament				
Endodontic Treatment	Pulp Vitality Test				
	Pulpotomy				
	Palliative (Emergency) Pulpectomy				
	Root Canal Therapy				
	Apicoectomy/Periradicular Services				
Oral Surgery	Routine Extractions				
	Surgical/Impacted Extractions				
	Biopsy				
	Alveoloplasty				
	Incision/Drainage of Abscess				
Restorative Treatment	Amalgam Fillings # Surfaces				
	Resin Fillings # Surfaces				
	Retention Pins				
	Inlay/Onlay Restorations				
	Cast Metal Crowns				
	Porcelain Veneer Crowns				
	Stainless Steel Crowns				
	Sedative Fillings				
	Core Build-Ups				
	Labial Veneers				
Prosthetic (Replacement) Treatment	Temporary Crowns				
	Fixed Bridges				
	Core Build-Ups				
	Removable Partial				
	Complete Dentures				
	Repair or Replace				
	Condition/Reline/Rebase				
Interim (Temporary) Appliances					
Miscellaneous Services/ Treatment	Cosmetic Services				
	Implants				
	TMJD Therapy				
	Orthodontics				
	Consultation				
	Office/House/Hospital/After Hours Visit				
	Other Drugs/Medicaments				
Sterile Pack Set-Ups Per Appointment					
<b>TOTALS</b>					
There will be a charge for each broken appointment if 24 hours notice is not given.				Initial Payment	
This estimate is guaranteed for only 90 days from the above date.				Balance Due	