FEE ESTIMATE FOR ______________________________ DATE ____________

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.

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
DIAGNOSIS AND PREVENTION	
❒ Oral Examination-Initial/Periodic Plus Probing	________
❒ X-Rays and Interpretation	________
❒ Diagnostic Models	________
❒ Oral Hygiene Instruction / Home Care Tool	________
❒ Prophylaxis – Routine Cleaning - No Perio	________
❒ Fluoride	________
❒ Sealants	________
❒ Emergency Dental Treatment – No Exam	________
PERIODONTAL TREATMENT - Case Type 1 2 3 4 5	
❒ Debridement Prior to Exam	________
❒ Periodontal Root Planing and Scaling	________
❒ Subgingival Irrigation	________
❒ Periodontal Home Care Tool	________
❒ Periodontal Maintenance	________
❒ Soft Tissue Surgery	________
❒ Osseous (Bone) Surgery	________
❒ Localized Therapeutic Medicament	________
ENDODONTIC TREATMENT	
❒ Palliative Pulpectomy	________
❒ Root Canal Therapy	________
❒ ____________________	________
SURGICAL TREATMENT	
❒ Extractions	________
❒ ____________________	________
RESTORATIVE TREATMENT	
❒ Cast Metal Crowns	________
❒ Porcelain Veneer Crowns	________
❒ Crown Buildup	________
❒ Amalgam Fillings	________
❒ Tooth-Colored Fillings	________
❒ Inlay/Onlay Restorations	________
❒ ____________________	________
PROSTHETIC TREATMENT	
❒ Fixed Bridges - Metal / Porcelain	________
❒ Removable Partials - Upper / Lower	________
❒ Full Dentures - Upper / Lower	________
❒ Relines - Upper / Lower	________
❒ ____________________	________
MISCELLANEOUS SERVICES	
❒ Cosmetic / Bleaching	________
❒ TMJD / Therapy	________
❒ Sterile Pack Setups / Per Appointment	________
❒ Other Drugs / Medicaments	________
❒ ____________________	________

There will be a charge for each broken appointment if 24 hours notice is not given.	TOTALS		
	ADJUSTMENTS		
This estimate is guaranteed for only 90 days from the above date.		TOTAL DUE	

FEE ESTIMATE