TODD bullard
FAMILY DENTISTRY

Patient Name: _____
Best Phone #: [C] [H] [O] _____
Address: _____
_____
Email: _____

CONSENT FOR DENTAL TREATMENT

I authorize Dr. Todd Bullard and/or his staff to provide general dental care to me and/or my legal dependents. I understand this treatment may include the following:
Taking radiographs (x-rays)
Dental prophylaxis (cleaning) with hand instruments, ultrasonic instruments, and/or air polishers
Topical fluoride application
Administration of anesthetics
Operative procedures (sealants, fillings, crowns/bridges, veneers)
Surgical procedures (extractions/sutures)
Prosthetic procedures (dentures, bleaching trays, bruxism/snore appliances)
Endodontic procedures (root canals)

I understand that the rationale for, risks associated with and other options for treatment(s) will be explained verbally to me by Dr. Bullard and/or his staff before services are rendered. I understand that if I have ANY questions regarding the nature or risks of treatment, I am encouraged to express them BEFORE treatment is initiated.

_____ _____
Patient or Parent/Guardian Signature **Date**

Do you have dental insurance: [Yes] [No]
Insurance Company: _____
Subscriber: _____
[Please present new insurance card]

STATEMENT OF FINANCIAL POLICY

We consider providing high-level dentistry and excellent customer service to be our commitment to you. In return, we ask that you commit to honoring the terms of our financial policy. Please read the items below, and acknowledge acceptance of these terms with your signature. Please ask if you have any questions. Payment for all services is expected at the time of treatment.

We accept cash, check, MasterCard, Visa, American Express, and Discover.

Regarding Dental Insurance Benefits: As a courtesy, we will file an insurance claim on your behalf. Please keep in mind that Dental Insurance is a benefit and only meant to assist you in the payment of your dental treatment. We will do our very best to estimate "what insurance will pay" and "what you will pay." You will be asked to pay your portion at the time of treatment. If we cannot obtain payment from your insurance company-for any reason-within 60 days from the treatment date, you must pay the unpaid balance at that time. It is very important for you to understand that you are responsible for your balance, not the insurance company. Please also understand we cannot be responsible for confirming every aspect of the policy that affects the payment of benefits, i.e., dates that policies begin or terminate, waiting periods, or exclusions of certain procedures.

We offer financing of treatment through CareCredit. Please ask for details.

I have read and understand the above information. I understand that if my insurance company has not paid a claim at 60 days following the date of treatment, I will immediately remit this balance to Dr. Bullard.

_____ _____
Patient or Parent/Guardian Signature **Date**