

CONSENT and BILLING FORM



This form is to obtain your consent for dental treatment or oral surgery procedures. Please read this form very carefully and ask us about anything that you do not understand.

Dental Billing Information

Patient Name: _____
Address _____
City _____, IL, ZIP _____

Guardian Name _____
Address _____
City _____, IL, ZIP _____

Phone number(s) where you can be reached during daytime hours during our clinic days
cell: _____
home: _____
work: _____

Which address do we bill to [] Patient Address [] Guardian Address

We proudly accept Medicaid and Private Insurance

Name of Private Dental Insurance Company _____ Insurance Phone Number _____
Group Number _____ Employer Name _____ Company Phone _____
Address to send Claims (on card) _____
Name of Person under whom patient is covered _____ Birth Date of Insured Adult _____
Social Security Number of insured adult _____ Contract/Policy ID number _____

(If possible attach photocopy of front and back of card)

Medicaid: 9- Digit Medicaid Recipient ID Number _ _ _ _ _

I hereby authorize payment of medical benefits to Jason M. Grinter DDS PC for the services described.

I give my permission to the doctor to submit insurance benefit claim forms in my name and on the behalf of myself, my spouse and/ or my minor patient.

I realize that I may be responsible for and agree to pay any charges not covered by my insurance. This includes unmet deductibles, non-covered services, etc.

A. Below is a list of dental procedures that may be performed on your patient. A treatment plan will be made for your patient and presented to you after the initial examination. Prior to each appointment the specific treatment that will be performed on your patient that day will be explained to you.

- 1. Diagnostic Procedures: Examination, radiographs (x-rays) of the teeth & jaws, consultation, photographs, dental casts.
2. Teeth Cleaning: Removal of soft and hard deposits on teeth, and teeth polishing with special toothpaste.
3. Fluoride Treatment: A solution of fluoride is placed on teeth after cleaning. Fluoride hardens the surface of teeth and helps them resist tooth decay.
4. Dental Sealants: Plastic sealants are applied to the grooves of the chewing surface of newly erupted permanent molar teeth to help resist tooth decay.
5. Local Anesthesia Injection: "Numbing medicine" carefully used to numb the teeth and surrounding areas prior to certain dental procedures such as tooth removal and dental fillings
6. Dental Rubber Dam: A sheet of latex rubber used to carefully isolate the teeth that need dental treatment.
7. Dental Fillings/Crowns: Depending on the size of tooth decay, and location of tooth in the mouth, the following may be done. Front teeth: white filling/crown. Back teeth or canine teeth: silver amalgam filling or stainless steel crown.

8. **Pulp (tooth nerve) Treatment/ Root Canal:** A procedure to save baby teeth and certain permanent teeth that would otherwise be lost because of a deep cavity that has affected the tooth nerve. Saving a baby tooth that would normally be expected to remain in the mouth for nine months or more is recommended because it provides the patient with a chewing surface. Also, baby teeth serve as natural space maintainers for the adult teeth growing underneath them.
9. **Extraction (Removal) of Teeth:** Teeth may be removed because of infection, injury, orthodontic reasons (teeth crowding), or if they are diseased and cannot be saved by any dental procedures.

Do you wish you be contacted before procedures such as extractions? [yes] [no]

If we are unable to contact you and yes is circled we will not proceed with treatment that day.

- B. The nature and purpose of the treatment and procedures have been explained to me in general terms by the dental staff of Jason M. Grinter DDS PC. Alternate procedures or methods of treatment if any, have been explained to me. I have also had the advantages, disadvantages, risks, consequences and probable effectiveness of each explained to me, as well as the prognosis if no treatment is provided.
- C. I am advised that though the results of the treatment are expected to be good, the possibility and nature of complications cannot be accurately anticipated for each individual. Therefore, there can be no guarantee as expressed or implied either of the result of the treatment or of the cure.
- D. **Risks and Complications:** Although their occurrence is not frequent, some **risks and complications** are known to be associated with dental or oral surgery procedures. The **more common complications** associated with special needs dental treatment include **nausea** following the administration of **topical fluoride** and patient **biting** and **injuring** their **tongue or lip** following the administration of **local anesthesia**. **Less common complications** include the risks of numbness, infection, swelling, prolonged bleeding, discoloration of tissues, vomiting, allergic reactions, swallowing or aspiration of dental materials, an extracted tooth or gauze packing; injury to the tongue or lips, damage to and possible loss of existing teeth and or fillings, injury to nerves near the treatment site, and fracture of a tooth root which may require additional surgery for its removal. **For patients with certain heart diseases, the risk of Infective Endocarditis (heart infection) following certain dental procedures exists.** Therefore, antibiotics will be prescribed before the treatment, to minimize the risk. I further understand and accept that complications may require additional medical, dental or surgical treatment that may require hospitalization.
- E. I hereby acknowledge that I have read and understand this consent form. I have been given an opportunity to ask any questions that I might have. All questions about the procedures have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions, which may arise during the course of my patient's dental treatment. I also understand that I am free to withdraw my consent to treatment at any time. This consent shall remain in effect until I choose to terminate it.

Do you have any objections? _____ Yes _____ No

If yes, please explain? _____

- F. By signing this consent form, I authorize and direct the dentist assisted by the dental staff of his/her choice, to perform upon my patient (or legal ward for whom I am empowered to consent) the dental treatment or oral surgery procedures explained herein.

Today's date: _____ Time: _____

Patients Name: _____ Date of Birth: _____

Printed Name of person completing form _____ Signature of person competing form _____

Your relationship to patient: _____ Are you legally responsible for this patient? _____ Yes _____ No

These forms are meant for legal guardians to sign, if you are a facility agent and have authority to make medical decisions for your patient, please provide a copy of that document for our records.

Patients with Office of State Guardian (OSG) guardianship must have this consent signed by OSG prior to the appointment