Cormier Dental & Associates
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STANDARD OF CARE AND CONSENT TO TREATMENT

Dear Esteemed Patient,

At ***Cormier Dental & Associates***, we have a ***Standard of Care*** that permits us convey and promote the knowledge, value, practice, and behavior that support and enhance oral health. Dental hygiene is the discipline of the recognition, prevention and treatment of oral diseases and conditions as an integral component of total health. The dental hygiene diagnosis requires evidence-based, clinical assessment and interpretation of several components in order to reach conclusions about your dental hygiene and treatment needs.

Components of the clinical assessment include an examination of the head and neck and oral cavity including an oral cancer screening, periodontal charting, documentation of normal or abnormal findings, and assessment of the tempromandibular function. A *current and complete* set of radiographs every three (3) to five (5) years, and bitewing radiographs every year, provides needed data for a comprehensive dental and periodontal assessment. Sometimes additional radiographs are recommended on an as needed basis. A comprehensive periodontal examination every six months is also part of clinical assessment.

Failure to abide by these standards could result in the deterioration of your dental health.

CONSENT

I understand that all treatment options for my dental condition will be fully explained to me prior to beginning treatment. It is my responsibility to complete treatment and follow recommended maintenance schedules. If I do not proceed with my treatment plan in a timely manner, if maintenance plans are not followed and/or appointments are missed, adverse results could affect my dental health. Further treatment for the involved teeth, supporting tissues, adjacent and opposing teeth, muscles or joints will be based on standard professional office fees.

TREATMENT FEES

Fees are *estimates only*, are valid for **6 months** from the date given and are subject to revision. Treatment could be altered if my dental needs change. I will be notified of any change(s) in treatment.

ESTIMATED INSURANCE COVERAGE

Estimated insurance coverage is an *estimate only*, not a guarantee of payment or benefits. I understand that I will be responsible for insurance claims not paid within 60 days of service.

ACKNOWLEDGEMENT

I promise to pay for any time, materials and laboratory expenses incurred in my behalf. I further understand that any balance over 60 days past due may be subject to a finance charge and that I may be liable for any and all fees incurred in collecting a delinquent balance.

I have read and understood in entirety the above:

PATIENT INITIALS _____

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PATIENT NAME: _____ **DATE:** _____

SIGNATURE: _____
(Parent or Guardian if Patient is a Minor)

DENTAL OFFICE WITNESS: _____ **DATE:** _____

SIGNATURE: _____