Insurance Information

Child's Parent or Guardian_____

Work Phone_____Cell Phone_____

Name of Dental Insurance Plan_____Group#_____

Name of person who holds insurance(the cardholder)_____

If the patient is not the cardholder, please provide the following information we must have to file your insurance:

Where does the cardholder work?_____

What is the cardholder's Social Security number?_____

What is the contract number?_____

What is the group number?_____

What is the cardholder's date of birth?_____

What is the cardholder's relationship to the patient?_____

Please initial:

_____Insurance coverage is **estimated** based on information available at the time of service. Estimated patient co-pays and deductibles are due at the completion of each appointment.

_____Any portion remaining after insurance pays is due directly by patient.

Informed Consent

As with any medical procedure, dental treatment involves some risk of complications.
The most common are:
(1) adverse reactions to drugs or anesthetics
(2) post operative pain, bleeding, or infection
(3) treatment failure requiring tooth extraction
(4) nerve damage causing prolonged or permanent lip, tongue, or gum tingling or numbness
(5) jaw or joint pain
(6) broken instruments
(7) sinus perforations

If a problem occurs after treatment, please call our office for any necessary follow up care.

There are often alternative procedures available for dental problems, one of which is no treatment at all. Please feel free to question Dr. Grantham or any team member at any time about alternative treatments.

If I ever have any changes in my health, I will inform the office staff or change my medical history.

I have read and understand the preceding risks.

Signature:_____Date:_____