Dental Procedure Consent and Payment Agreement

Please read this document carefully. By signing below, you acknowledge that you understand the proposed treatment, the associated risks, and the financial obligations related to your dental care.

Patient Information

Patient Full Name: _____

Date of Birth (MM/DD/YYYY): _____

Phone Number: _____

Address: _____

Proposed Dental Procedure(s)

Description of Recommended Treatment: _____

Tooth Number(s) / Area(s) of Mouth: _____

Informed Consent for Treatment

I hereby authorize the dental clinical team to perform the dental procedures outlined above. I understand that clinical dental treatments involve certain inherent risks. These risks include, but are not limited to:

- Temporary or permanent numbness, pain, or swelling in the treated area.
- Sensitivity of teeth to hot, cold, or pressure.
- Infection, bleeding, or bruising.
- Damage to adjacent teeth, restorations, or surrounding tissues.
- Failure of the treatment requiring additional procedures or extraction.

I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the alternatives to the proposed treatment, including the option of no treatment and the risks associated with that choice.

Financial and Payment Agreement

Total Estimated Cost of Treatment: _____

Estimated Insurance Coverage (if applicable): _____

Estimated Patient Out-of-Pocket Responsibility: _____

Payment Terms

By signing this agreement, you agree to the following financial terms:

- Payment is due at the time of service unless prior financial arrangements have been made.
- Insurance is billed as a courtesy. However, you are ultimately responsible for the entire cost of treatment regardless of insurance coverage, denials, or benefits.
- A monthly service fee or finance charge may be applied to balances unpaid after 30 days.

Agreed Payment Method (e.g., Cash, Credit, Payment Plan): _____

Signatures and Acknowledgement

By signing below, I certify that I have read, understood, and agree to the terms of both the Dental Procedure Consent and the Payment Agreement.

Patient or Legal Guardian Signature (Print Name): _____

Date Signed (MM/DD/YYYY):

Witness / Dental Office Representative Signature (Print Name):