



FAMILY DENTISTRY

Office Guidelines

Thank you for being a valued patient of Sierra Family Dentistry. Please take a moment to read and sign our policies.

Insurance/Financial Responsibilities

- We are contracted with most insurance plans. These plans may have a co-payment or deductible. We expect **payment at time of service**.
- Each insurance plan is different and has its own policies on what is and is not a covered benefit. ***IT IS YOUR RESPONSIBILITY TO KNOW WHAT IS COVERED AND WHICH BENEFITS FALL UNDER YOUR PLAN.***

Delinquent Accounts

- Account balances should be paid within 30 days of the account statement.
- Outstanding balance after 90 days will be transferred to a collection agency unless prior arrangements have been made with our business manager.

Cancellations of Appointments/No Show

When you do not show for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It's very important that you call with in 24 hours in advance to cancel your appointment.

- On your second no show occurrence, there will be a \$50 charge to your account.

Returned Checks

- There will be \$50 service fee for any check returned for insufficient funds.
- After one returned checks we will no longer accept checks as your form of payment.
- **No postdated checks allowed.**

Concerns

* Patients under the age of 18 must always be accompanied by an adult for the duration of the appointment.

If you have any concerns regarding our office, please feel free to speak to our office manager so that we may address any issues.

Patient Records

If you require your records to be e-mailed to you or another office, there will be a charge of \$25.

Acknowledgement of Receipt of Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. You may request a copy of our Notices at any time.

I have read and understand the above policies.

Patient Signature

Date

600 S. Dobson Rd. Bldg B. Suite 8 | Chandler, AZ 85224
P: 480.899.3425 | F: 480.899.5926

www.ChandlerSmiles.com



FAMILY DENTISTRY

1. I hereby authorize and direct the dentist(s) of Sierra Family Dentistry and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedures(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
 - A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
 - B. Application of plastic "sealants" to the grooves of the teeth.
 - C. Treatment of diseased or injured teeth with dental restorations (filings and crowns).
 - D. Replacement of missing teeth with dental prostheses (bridges, partial dentures, full dentures).
 - E. Removal (extractions) of one or more teeth.
 - F. Treatment of diseased or injured oral tissues (hard and /or soft).
 - G. Treatment of malposed (crooked) teeth and/or oral develop or growth abnormalities.
2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explain to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand same.
3. I agree to the use of local anesthesia, nitrous oxide/oxygen analgesia, sedative drugs, physical restraints or voice control depending on the judgment of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of dentist.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site, fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
6. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.
7. I will be advised that the success of the dental treatment to be provided will requires that the patient and the parents follow post-operative and post-care instructions of the dentist(s). I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visit as scheduled by my dentist and his/her auxiliaries must be maintained.
8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.
9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Patient's Name/Patient's Signature

Date

Name of Parent

Relationship of patient

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