Sona Georgian D.D.S. Inc

OFFICE POLICY

A $50.00 charge will be made for all cancellations unless **48 hours** notice is given.

Payment is due when services are rendered unless prior arrangements are made. Appropriate financial arrangements can be made With the Office Manager before the **start** of the treatment. This includes financing with Care Credit.

I hereby understand that if dental benefits apply to my treatment, nothing is guaranteed as payment from the insurance company until the actual claim is received. I understand that the office of Sona Georgian D.D.S. will bill my insurance as a courtesy to me. If there is any reason insurance does not pay for the elected services, I am therefore responsible for any incurred charges.

Patient Signature_____Date _____

DENTAL MATERIALS FACT SHEET

I, _____, acknowledge that I received a copy of Dental Materials Fact Sheet

Patient Signature_____ Date _____

INFROMED CONSENT FOR DENTAL TRETMENT **INITIALS**

I understand that I am having the following work done today: X-rays and Exam _____

I understand that I am having the following work done today: Prophylaxis _____

I understand that dental anesthetic can cause allergic reactions such as redness and swelling of tissue

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I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, for example, root canal therapy following routine restorative procedure. I give my permission to the dentist to make any/all changes and additions as necessary.

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I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid fracture.
I understand that a more extensive filling that originally diagnosed may be required due to additional or extensive decay
I understand that significant sensitivity is common after the placement of a new filling.

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I hereby authorize Sona Georgian D.S.S. to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosed circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

Patient Signature _____ Date _____