



# Dental Treatment Consent

**TIM M. VERWEST, DMD**

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8016 Summerlin Lakes Drive | Ft. Myers, FL 33907

Patient Name: \_\_\_\_\_ Account #: \_\_\_\_\_

I do hereby authorize and request the performance of dental services for my child and the use of whatever procedures Dr. Verwest and staff may deem necessary during treatment. I understand that Dr. Verwest and his assistants will use preventive, restorative, oral surgery, and patient management techniques that are reasonably necessary, and advisable. I also authorize the administration of anesthetics, or analgesics which may be deemed advisable by Dr. Verwest. I understand that though he will do his best to provide Quality dental therapy, no guarantee is given or implied by Dr. Verwest or his staff for services rendered. I understand that the treatment plan, and fees could change depending upon the extent of dental disease and the time elapsed since the initial examination. I also authorize release of this information to the patient's medical doctor of record.

\_\_\_\_\_  
PARENT OR GUARDIAN

\_\_\_\_\_  
DATE

## FINANCIAL

METHOD OF PAYMENT (PLEASE CHECK ONE)

1.  CASH     CHECK – *Full payment for completed treatment at appointment*

2. CREDIT CARD:     VISA     MASTERCARD

3. INSURANCE: Company Name \_\_\_\_\_

Policy # \_\_\_\_\_ Company Phone# \_\_\_\_\_

Address: \_\_\_\_\_

4. CITY HEALTH OR CARE CREDIT AVAILABLE

## PLANNED TREATMENT

Most insurance companies pay only a portion of the fee for dental treatment. The amount they pay is based upon your insurance policy. We will be glad to work with your company, but it is important to remember that its your responsibility to make up the difference is cost that your company does not pick up.

\_\_\_\_\_  
PARENT OR GUARDIAN RESPONSIBLE FOR PAYMENT

**Please be advised we have specially reserved time for your child to be seen in our office. Should you not show up or cancel with less than 24 hours there is a broken appointment fee that must be paid prior to rescheduling.**

\_\_\_\_\_  
PARENT OR GUARDIAN