DENTISTRY for Children

Troy L. King, DDS

Patients Name:_____ Date:_____

We appreciate you allowing us to provide dental care for your child. Because we value our relationship with you and believe that the best relationships are based on understanding, we offer these clarifications of our office policies.

Dental Insurance: The type of plan chosen by you/your employer determines your insurance benefits. As such, we have no say in the selection of your insurance plan, contracts, method of reimbursement, or the determination of insurance benefits.

Pre-treatment authorization: Some insurance companies recommend an estimate of the work to be done and the fees to be charged before determining their benefits to you. If so, we will provide you with the pre-treatment fee estimate. In this case, it will be up to you to determine if you wish to proceed with the treatment before the insurance benefits is determined.

All emergency treatment must be paid in full at the time the service is rendered.

The ADA recommends fluoride treatments 2 x year. It is your responsibility to know the coverage.

I,_____ give my permission for the following persons to accompany my child to their dental appointments. I give them the full responsibility to make any decisions for necessary treatments. I understand that I am responsible for the payment at the time of service and should someone else other than myself, payment agreements must be made in advance.

Name	Relationship to child
_____	_____
_____	_____
_____	_____

If the child is of driving age, are they allowed to come alone and/or with other siblings?
YES ___ OR NO ___

I have read and understand all office policies listed above, and abide by its contents:

Parent/Guardian:_____ Date:_____