NATICK DENTAL PARTNERS

Drs. Kane, Soporowski & Mahdavi

.

AUTHORIZATION TO RELEASE INFORMATION

Date: _____

I, _____ give my permission to Natick Dental Partners and staff to discuss treatment provided and treatment recommended with the persons listed below until such time as I notify Natick Dental Partners and staff in writing that I am rescinding this authorization:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signed: _____

NATICK DENTAL PARTNERS
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Please choose and sign either option 1 or 2

1. I, _____ give my permission to have topical Fluoride treatments, I understand that these treatments may not be covered by my dental Insurance.

Patient Signature: _____

Today's date_____/_____/_____

2. I, _____ do not give my permission to have topical Fluoride treatments.

Patient Signature: _____

Today's date_____/_____/_____

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INFORMATION REGARDING FILLINGS

White vs Silver

After a thorough comprehensive examination, Natick Dental Partners may recommend a restorative procedure (filling) or several restorative procedures (fillings) for your child. Please be advised:

We no longer use silver (amalgam) fillings on primary (baby) teeth due to the substantial improvement in composite/resin (white) filling materials. These new materials have been found to perform better than the amalgam restorations on primary teeth. (We may still recommend, on occasion, silver (amalgam) fillings in certain cases for permanent (adult) molars.)

Please be aware that if your *insurance policy* does not cover composite/resin fillings, your co-payment will be higher. The balance is the patient's responsibility.

Please contact your insurance company for further explanation.

All policies are different and it is very important, if finances are a concern, to file a pretreatment estimate with your insurance company for the treatment plan recommended. We will be happy to do that for you at your request.

In every case Natick Dental Partners will make a recommendation as to the material to use that is in your best interest. Please discuss the treatment beforehand if you have a concern about the recommendation made. We welcome your input.

Name of Patient (Please print): _____

Patient Signature (Over 18): _____

Date: _____

NATICK DENTAL PARTNERS

Drs. Kane, Soporowski & Mahdavi

Dear Adult Practice Patients,

At Natick Dental Partners, we understand that you may need to change your existing appointment in our office. Our adult schedule is in very high demand. Therefore, in respect to your fellow patients, we ask you to provide our office with at least a 48-hour notice for any cancellations and/or reschedules. This will allow other adult patients who may be waiting for an appointment to be put into the schedule.

If we receive less that 48-hour notice, a fee equal to the length of your appointment will be charged to your account (i.e. a 45 minute appointment = $45.00). This same fee will also be assessed if you miss an appointment. We do understand and will take into account extenuating circumstances.

Our intent is not to penalize our patients, but to help us provide proper staffing to better meet the dental needs of our patients.

After reviewing our policy, please sign the agreement below.

I have reviewed and understand Natick Dental Partners' *Adult Late Cancellation and Missed Appointment Policy.*

_____

_____

Parent/Patient Signature
Date

_____

List name(s) of patients (if under 18 years old)