Platinum Dental Care
Dr. Marlene Beeson
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Forest Park, IL 60120
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Consent To Treatment

Cancellation Policy:
A fee will be charged for less than 24 hours notice if cancelling an appointment.

Authorization:

If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. To the best of my knowledge, all of the preceding information is true and correct.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependents(s) to third-party insurance carriers, payors, and / or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that aren't fully covered by insurance, and I may be billed for the remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Our patients are very important to us! We carefully schedule and prepare for each patient appointment so that our doctor and staff can focus solely and attentively on the needs of the patient in the chair. When a patient fails to show up for a scheduled appointment, it wastes time and materials that could be utilized by another patient and delays necessary treatment. Effective October 1, 2011, patient appointments cancelled with less than 24 hours notice and missed patient appointments will incur a cancellation fee. Please don't disappoint us by missing your scheduled appointments, we really look forward to seeing you!

Print the name of the patient, parent, or guardian:

Printed Name: _____ _____
First Mi. Last Date

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship To Patient: _____