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Consent Form

I, the □ Patient □ Parent /Guardian □ POA □ Other (specify) _____ consent to having treatment provided by Portable Dental Services for:

_____ (patient's name).

I understand that Portable Dental Services provides all aspects of General Dentistry including: examinations, x-rays, cleanings, gum treatment, extractions, fillings, dentures, partial dentures, root canals, crown and bridge work.

I understand that an appointment has to be made for the patient to be seen.
I understand that when becoming a new patient, either a full-set of x-rays will be taken or a recent full-set (within 5 years) will be provided. If a full-set from another office is provided within the last 5 years, either current bite-wings also need to be provided or bite-wing x-rays will be taken at that appointment.

I understand that Portable Dental Services does not participate with insurance, but will submit all the necessary claim paperwork to the dental insurance company on behalf of the patient for direct reimbursement to the patient. Portable Dental Services does not participate or work at all with Medicare or Medicaid. I also understand that treatment could be obtained elsewhere and that obtaining duplicate services may affect benefits that he/she receives from private dental, a state or federal program, or other third-party provider of dental benefits.

Signature: _____ Date: _____