In-House Dental Care

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Welcome to In-House Dental Care

This notice describes how our office policy works in regards to your dental treatment consent, insurance payments and financial obligation to our mobile service. Please review it carefully and if you have any questions let us know.

Thank you for choosing our unique Mobile Dental Service. During your first visit, our objective is to get to know you better, to become familiar with your past dental treatments and to establish a treatment plan that will best meet your dental needs. When we arrive, please be prepared to answer questions relating to your dental concern/s so that it will help us to get to know you and get you acquainted with our mobile service.

The initial appointment will last approximately one to two hours which includes the examination, dental x-rays and dental photos. In most cases, we will clean your teeth the same day. After the examination, Dr. Richard Nguyen will provide a detailed summary that outlines any existing dental problems and proposed treatment.

We believe that patient compliance to good dental care begins with open communication. We want to work together so that we can achieve one common goal — keeping your teeth, gums and maintain a healthy smile for life!

I. Informed Consent as a "Patient": I understand that I may be having the following work done: Oral Evaluation, X-rays, Photos, and Cleaning. If needed, other treatments such as Deep Cleaning, Fillings, Crowns/Bridges, Root Canals, Extractions and Dentures Consent Forms will be provided separately. (Initials _____)

II. General Information:

DRUGS AND MEDICATIONS

I understand that antibiotics, analgesics and other medications can cause allergic reactions: redness, swelling, pain, itching, and/or anaphylactic shock. (Initials _____)

CHANGE IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination. For example, root canal following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions necessary. (Initials _____)

III. Office Hours and Appointments: Office Hours: By appointments only.

Appointments

Due to the nature of our service, travel time are all incorporated into your appointments. This time has been reserved specifically for you and therefore a "VOID" in our schedule is harder to fill. As a courtesy to others who may need emergency visit from us, we request a 48-hour notice if you need to cancel or reschedule your appointment so that we are able to accommodate emergency appointment in place of yours. We are aware that unforeseen events sometimes will occur and unavoidable- should this occur, please call or you may "TEXT" us immediately on our mobile number at **949-872-4529**.

IV. Dental Insurance Authorizations and Release: ☐ I have NO Dental Insurance

We do not accept any dental insurance as payment. As a courtesy, we will submit a dental claim in your behalf and have the insurance reimburse you directly. Because insurance policies vary, we cannot guarantee coverage due to the complexities of your insurance coverage. We will mail the claim form to your insurance but it is your responsibility to follow up regarding reimbursement. If you or your insurance have any questions, we are always available to answer them. For reimbursement purposes, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. (Initials _____)

V. Financial:

I understand that I am fully responsible for all services rendered that are presented to me. (Initials _____)

I understand that dental treatment may be recommended based on the dentist's findings. I will not hold "In-House Dental Care" responsible for the oral health consequences or results should I choose **not** to have treatment as recommended. I understand that dentistry is not an exact science and therefore reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested/authorized. (Initials _____)

I hereby authorize any of the doctors at this facility and dental auxiliaries to proceed with and perform the dental procedures and treatments as had been explained to me. I understand that an estimate will be provided and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I certify that I have read and fully understand the above consent to dental treatments and that the explanation herein referred to were made. I am also aware that a copy of this policy is available to me upon request and anything I did not understand has been explained to me.

Patient's Name: _____

_____ _____ _____

Print Name of Responsible Party/POA (if other than self) **Signature** of Responsible Party/POA Date