

TREATMENT CONSENT

Patient Name _____

Subscriber (if different) _____

Date of Birth _____

Dentist Name _____ **Office Location** _____

In-network Dentist Yes _____ No _____

OPTIONAL/NON-COVERED TREATMENT WORKSHEET (In lieu of a consent form your office may already have in place.) Please retain a copy of this worksheet as proof of consent for treatment.

Dental Service	Dentist's usual fee for treatment procedure	Total paid by Dental Plan	Patient's covered treatment co-payment	Additional Patient Payment due for Optional/Non-Covered Treatment	Total cost to Patient
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$

TOTAL COST TO PATIENT FOR TREATMENT \$ _____

_____ I hereby accept all dental procedures listed above for myself or dependent child. If I decide to proceed with treatment, I also acknowledge and accept the additional charge(s) noted above.

Signature _____ **Date** _____

Relationship to dependent child if applicable _____