DIAMOND DENTAL
of Sacramento

SHEETAL PADVAL DDS INC
2711 Watt Avenue, Sacramento, CA 95821
916-483-5900

Office Policies and Consent Agreement

Patient's Name: _____ Date of Birth: _____
Last *First* *Initial*

GENERAL INFORMATION ON DENTAL TREATMENT

BENEFITS: The benefits of dental treatment include, but not limited to: restoration of proper form and function, improvement of chewing efficiency, replacement of missing teeth, elimination of odors, prevention of gum disease or decay, prevention of fractures, elimination or prevention of infection and pain, improvement of oral hygiene, diagnosis of oral pathology with appropriate treatment, and improved esthetics.

COMPLICATIONS: Any dental work may cause the following complications: pain, swelling, infection or abscessing, numbness of jaw or other areas, redness, discoloration of teeth or tissues, jaw fracture, nerve damage, nausea and vomiting, bruising, damage to nearby soft tissues, discomfort, temperature sensitivity, tooth loss, TMJ complications, occlusal discrepancies, damage to other teeth or restorations, inflammation, fainting, shock, hypersensitivity, bleeding or other consequences. Administration of drugs, anesthetics, prescription medications, nitrous oxide or dental materials may also cause these same complications as well as anaphylactic shock, cross reactions with other medications or allergic reactions. Changes to treatment may also be indicated based on the findings during the procedure.

CONSEQUENCES: Consequences of not performing dental treatment include, but not limited to: loss of teeth, infection, pain, discomfort, tooth fracture, drifting, gum disease, halitosis, swelling, inability to properly diagnose oral pathology or other unforeseen problems.

ALTERNATIVES: Alternatives to dental treatment include: extractions, root canal treatment, partial dentures, full dentures, crowns or bridges, different filling materials, referral to specialists, implants or no treatment.

OFFICE POLICIES

Providers: Dental diagnosis and treatment is provided by licensed professionals. Dr. Sheetal Padval, DDS, may at her discretion assign other dentists or dental professionals to provide dental diagnosis and treatment for patients. Due to the varied abilities of each provider, similar procedures are performed at different speeds and may be completed using different methods. Despite the differences in treatment style, all treatment is performed to the standard of care in the community.

MISSED APPOINTMENTS: We request at least 24 hours' notice to change appointments. *A pattern of cancelled appointments or failure to keep appointments may result in a $50 missed appointment charge or dismissal from the office.* This applies to patients who are frequently late also.

CHILDREN: We will attempt to treat children three years and older. If the child does not cooperate, we will refer the child to a pediatric dentist. Parents are welcome to sit in the treatment room during treatment as long as it does not interfere with the treatment. Young children should not be left unattended in the office.

DENTAL AMALGAM: Silver amalgam is an alloy that contains silver, copper, tin or other metals and mercury. Our office does not place silver amalgam and we generally use composite instead which is a tooth-colored restorative material.

PHOTOGRAPHY: Intraoral and extraoral photography are used to educate, document and diagnose. All photos remain property of Sheetal Padval, DDS, Inc. and maybe used for educational, collaborative and marketing purposes without remuneration to the patient.

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SEDATION: Oral conscious sedation in words the patient taking medication already to reduce dental anxiety any patient who opts to be sedated is required to have a licensed driver bring them to the office and take them home following the appointment failure to have a driver will force cancellation of the appointment and forfeiture of any deposit made the dental office is not liable for any damages prior to or following the appointment resulting from being sedated.

FINANCIAL AGREEMENT

PAYMENT DUE AT THE TIME OF SERVICE: *Payment of fees is due at the time of service. Failure to pay fees may result in late charges, accounts being sent to collections and/or dismissal from the office.* Patients with insurance are expected to pay their co-payments before leaving the office. We have financing available through third parties. Ask the receptionist for more details.

INSURANCE: Insurance coverage is variable based on the company and the plan. *It is the **patient's responsibility** to know their coverage.* We will try to contact your insurance carrier to verify coverage and obtain an explanation of benefits; however, *these are only **estimates***. We will bill the insurance company for the fees as a courtesy and collect your portion at the time of service. If your insurance company fails to pay their estimated portion, the patient will be billed for the difference. *It is the **patient's responsibility** to know about limitations such as waiting periods or pre-authorization requirements*. Please inform us if you have already used dental benefits in another dental office this benefit year.

PROSTHODONTICS: Crowns, bridges and dentures require multiple visits to complete. For these procedures, 50% of the patient portion is due on the first visit with the balance due upon delivery of the prosthesis. The initial fee is non-refundable if the patient does not return for final delivery.

RETURNED CHECKS: Returned checks will cause a $40 charge to be added to the patient's account.

CONSENT TO RECEIVE TREATMENT

I hereby consent to having an examination, appropriate diagnostic X-rays, and a simple cleaning on this and/or subsequent visits unless deemed inadvisable by the dentist. Possible complications from this treatment include radiation exposure, sensitivity, bleeding or loosening of fillings/crowns. Following the examination, a treatment plan will be presented to restore defects, deficiencies or other problems associated with my mouth, teeth and other oral conditions. If I am here for an emergency visit or consultation, I also consent to evaluation and appropriate treatment of the problem as will be discussed with the dentist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION AND OFFICE POLICIES AND AGREE TO ABIDE BY THEM. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signed: _____ Date: _____

Patient or Guardian

Receipt of Dental Materials Fact Sheet and Notice of Privacy Practices Sheet

_____ My dentist has provided a copy of The Dental Board of California's Dental Materials Fact Sheet.
Patient's Initials

_____ My dentist has provided a copy of the Notice of Privacy Practices.
Patient's Initials