Welcome to Delaware Maryland Dental!

Please take the time and read our office policies below. If you have any questions, please ask our knowledgeable front staff prior to signing.

- We do require payment at the time of service. If you are unable to pay for your visit, please let us know prior to any work. For any major work, (Bridges, Partials, Dentures) we will need to collect prior to the delivery.
- We do accept all forms of payment except American Express. **There would be a $35.00 service fee for any returned checks.**
- We proudly accept most insurance companies. We do collect all co-pays/coinsurances at the time of service by your insurance guidelines given to us. Unfortunately, there are times the insurance company may change coding and make your responsibility higher. This balance should be paid on or before your next appointment. ****our office only does the composite fillings (tooth colored). This may add additional charges as some insurance companies do not allow these.**
- To be able to give excellent patient care we ask for patients to be on time; however if an emergency does arise we will allow a 10 minute window for tardiness. After this time frame we would need to reschedule your appointment.
- We require 24 hours notice to reschedule or cancel an appointment. **For appointments not cancelled or rescheduled within 24 hours there is a $25.00 fee /half hour appointment was scheduled for.**
- Please do not eat or drink in the office.
- We require any minors (under 18 years old) to have a parent or guardian (if guardian we need letter from parent) present in the office at all times.
- To release your records we do require a signed release. We do require 7-10 business days to complete the duplication process. Our x-rays are now digital and would need to be e-mailed.
- Please notify staff of any personal or insurance information changes.

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Print and Sign Date

Patient Name:_____ Date of Birth:_____

Relationship to Patient:_____

Dental Treatment and Consent:

I understand that I may have cleanings, fillings, bridges, extractions, root canals, crowns, dentures or partials, and local anesthesia. With any and all dental procedures there are risks; such as numbness, swelling, bruising, cuts, abrasions, and tenderness.

I understand it may be necessary to change or add procedures because of conditions found while working on my teeth.

I understand that antibiotics, analgesics, and other medications may cause allergic reactions such as but limited to, nausea, vomiting, redness, swelling, itching, and in severe cases anaphylactic shock.

I understand it is of utmost importance to inform Delaware Maryland Dental of any changes to my medical history which includes diagnosis and medications. There are some surgeries and medications that are contraindicated with certain dental procedures and can affect dental treatment.

If you have any questions, please ask our staff prior to signing.

_____

Print and Sign Date

Patient Name:_____ Date of Birth_____

Relationship to patient:_____