MERCE Family Healthcare

Medical Center: 1831 North Fayetteville Street • Asheboro, NC 27203
Phone: 336-672-1300 / Fax: 336-672-3044

Dental Center: 308 Brewer Street • Asheboro, NC 27203
Phone: 336-610-7000 / Fax: 336-610-7003

GENERAL CONSENT FOR DENTAL TREATMENT

PURPOSE OF MERCE FAMILY HEALTHCARE CONSENT FORM

MERCE Family Healthcare is dedicated to providing quality dental and oral surgery care to provide relief from pain, bleeding, swelling, and infection. Our goal is to provide these services in combination with consultations and referrals to restore individuals to a state of sustainable oral health. We do provide full service dental care. We provide emergency and primary care only. **I understand Dentistry is not an exact science and complications may occur despite the best efforts of the dentists, staff, and myself/person of whom I am a legal guardian.**

MISSED/LATE APPOINTMENT POLICY

A missed appointment delays your planned treatment and wastes time that could be spent helping another patient. If you miss more than 2 appointments, you will be dismissed from the dental center. If you are more than 15 minutes late, your appointment will be rescheduled. We require a 24-hour notice if you have to reschedule an appointment. If the appointment is rescheduled over the phone, an appointment card will be mailed to you per your request only. Family members cannot be scheduled on the same day due to cancelled appointments. Usually if one member cancels, the others will also cancel.

PAYMENT FOR SERVICES/DENTAL INSURANCE

I understand that payment for services will be expected and that fees for service will be determined on a sliding fee schedule based on my family income and resources. I assume responsibility for the payment of all services I receive.

I understand that my dental insurance (if any) is a contract between me and the insurance carrier, and not between the insurance carrier and MERCE Family Healthcare; therefore, I assume complete responsibility for the payment of all services I receive regardless of any payments an insurance carrier may make. I understand that any payments received by MERCE Family Healthcare from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees.

TYPES OF SERVICES AVAILABLE

Dental treatment available at MERCE Family Healthcare is limited in scope. Additional treatment may be required to complete dental care. Your treatment needs will be explained to you. If you require services not provided by MERCE Family Healthcare, a referral will be made to a local dentist who may provide these services for you at your expense. MERCE Family Healthcare does not provide financial assistance for services other than those provided at our facility.

TYPES OF SERVICES NOT PROVIDED

The dental program at MERCE Family Healthcare is designed to assist people gain access to basic dental services and to relieve acute pain. MERCE Family Healthcare does not provide crowns, fixed bridges, gum surgery for periodontal disease, or root canal treatments.

RADIOGRAPHS (XRAYS)

X-rays are designed to help the dentist diagnose diseases of the teeth and jaw bones. They are used to show cavities in teeth, the shape of the tooth roots, and sometimes may show a cyst or tumor of the jaw bone or a wisdom tooth below the level of the gum and bone. Your dentist will order x-rays for your teeth based on your specific needs. If you had x-rays taken at another office recently, please let us know so that we may keep your x-ray exposure to a minimum.

REMOVAL OF TEETH

Removal of teeth may be required to alleviate dental pain or to remove the source of an infection in the mouth. Alternatives to the removal of teeth may be possible (root canal therapy, crowns, periodontal therapy) and I understand that the extraction of teeth is irreversible. Further, I understand that removing teeth does not always remove the symptoms, some of which are: pain, swelling, infection, bleeding, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (that can last for an indefinite period of time), or fractured jaw. I understand I may need further treatment or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

FILLINGS

Cavities in teeth are a frequent cause of tooth pain. If untreated, teeth may become badly decayed, loose and/or abscess. Large cavities in teeth may require medications and/or surgical treatment (extraction). However, if cavities are treated early (when they are small) teeth can be maintained for years longer than if no treatment was done. Fillings are designed to remove dental decay and restore teeth to function. They may be silver in color or tooth-colored. I understand that fillings can correct existing cavities but will not prevent new cavities from forming if the teeth are not carefully cleaned and maintained.

CLEANINGS

Cleanings are designed to maintain the health and beauty of your teeth and to prevent periodontal (gum) disease. A professional dental cleaning will remove deposits of calculus (tartar) from your teeth that you are unable to remove with your daily tooth brushing. Most adults require cleanings every three to six months. Your dentist/hygienist will be able to explain to you how often your teeth need professional cleaning.

DRUGS AND MEDICATIONS

I understand that during the course of treatment antibiotics and other medications may be indicated, and that they can cause allergic reactions such as redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reactions). I will inform the doctor immediately if I encounter problems with prescribed medications.

BY SIGNING THIS DOCUMENT, I UNDERSTAND AND AGREE WITH THE POLICIES AND PROCEDURES OF MERCE FAMILY HEALTHCARE.

I HEREBY REQUEST AND AUTHORIZE THE DENTISTS WORKING FOR MERCE FAMILY HEALTHCARE TO PERFORM ANY INDICATED DIAGNOSTIC PROCEDURES, DENTAL TREATMENT OR DENTAL SURGERY BASED ON MY DIAGNOSED DENTAL NEEDS AND THE CONDITION(S) FOR WHICH I AM SEEKING CARE. I UNDERSTAND THAT I MAY BE TREATED BY DIFFERENT DENTISTS AT DIFFERENT APPOINTMENTS.

Patient Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____