NORTH SHORE
PEDIATRIC DENTISTRY

Child's Name _____ **Birth Date** _____

Radiographs

Depending on need, x-rays may be taken to determine your child's present dental condition.

Should we need x-rays, North Shore Pediatric Dentistry will get consent first.

Insurance

We are happy to assist you in claiming benefits which you may be entitled to under your dental insurance. Since insurance policies vary considerably please be sure that:

1. You know what your benefits are before you start treatment.

2. You understand not all procedures required for your child may be covered by your dental insurance.

3. Your insurance carrier is responsible to you as set out in your policy and not to us.

4. There is a differential between our specialty fee and those fees provided by your insurance company which are in the general practitioners fee guide. If you have any questions in regards to your insurance coverage, you are responsible to obtain that information by calling your insurance carrier.

Payments

Payment for dental services are due when rendered. We accept Visa, MC, Debit and Cash only

Authorization

1. I authorize treatment or procedures as, in the opinion of the dentist, are necessary. The treatment may include: x-rays, cleaning, fluoride, white fillings (composite resins), silver fillings (amalgams), stainless steel crowns, composite crowns, nerve treatments (pulpotomies), extractions and spacers. The type of treatment and materials used are dependent on the location and size of the cavities.

2. I authorize the release of any records that are relevant to the processing and payment of dental insurance claims held by the service provider.

3. I authorize the electronic submission of dental claims to my insurance company (where applicable).

4. I understand this office collects personal information for the safe and efficient delivery of dental treatment and complies with provincial privacy legislation. It is understood that during the course of dental treatment. consultation with other medical and dental specialists may be required. With respect to any such consultation for the benefit of the patient. it is agreed that the identity of the patient, information relative to the patient's treatment, and the patient's records may be disclosed and made available to any other medical or dental specialists that are consulted.

I _____ **have read this letter and understand its content.**

Signed, _____ **Dated:** _____