NORTH WOODSTOCK DENTISTRY

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Implant Treatment Consent Form

Patient Name: _____ Date: _____

I authorize Dr._____ to perform my Implant Treatment.

Total Fee: $_____

Fee of 100% or 50% is $_____ collected on _____

Remaining _____% balance is $_____ to be collected on _____

Visa/Mastercard Pre-Authorization

_____ _____ _____

Visa or Mastercard Number (circle one) Expiry Date (MM/YY) CVV

_____ _____

Signature of Card Holder Name of Card Holder

Implant Appointments

Initial Prep: _____

Impressions (4 months after Prep): _____

Insert (2 weeks after Impressions; Lab delivery date may vary): _____

I am responsible for:

- Any changes/termination to my dental benefits occurring between the Prep. and Insert appointments.
- Paying upfront for all costs associated with the treatment.
- Any additional treatments occurring between the times of Prep. to Insert, which may or may not affect my limits within my dental benefits.
- A cancellation charge of $50.00 for any missed appointments, unless a 48 hour notice has been given.

I have read and understand the information above. I have discussed the treatment that is required. I am financially responsible for all charges whether or not paid by insurance. I wish to proceed with the recommended treatment.

_____ _____

Signature of Patient/Parent/Guardian (circle one) Date