CONSENT FOR FINANCIAL RESPONSIBILITY FOR DENTAL TREATMENT

LONG TERM CARE
ORAL HEALTH PROGRAM
HOME: ______________________________

Resident's full name: ____ Date: ________________________

The following treatment has been recommended:

Procedure	Cost	Procedure	Cost
❑ **Professional Oral Hygiene (scaling and fluoride varnish application)** Every: ❑ 3 months ❑ 4 months ❑ 6 months ❑ 12 months	$_______ each visit	❑ **Restorations (fillings)** ____ fillings	$_______ all fillings
❑ **Denture(s) labelling**	$_______	❑ **Tooth/teeth extractions** ____ extractions	$_______ all extractions
❑ **New denture(s) (complete or partial)**	$_______	❑ **Dental Radiographs**	$_______
❑ **Denture repair/reline**	$_______	❑ **Other:** _________________________	$_______

An institutional fee of $ ____________ is charged with each visit.

The estimated cost of the recommended dental treatment is: $ ______________

The dental procedures will be performed at:

❑ Bedside
❑ On-site in the Dental Clinic
❑ Other: ______________________________

I, the undersigned, will be responsible for the payment of the fees, or payment of fees not covered by insurance, benefits, etc. associated with this treatment. **I understand the costs are estimates, and treatment costs may exceed the estimated costs.**

Name: ____

Relation to Resident: __________________________

Address: ____

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Home Phone: (____) ___________________________

Business Phone: (____) _________________________

Email: ____

Cell Phone: (____) ______________________________

Signed: ____

Date: ____

Complete and sign the *Consent for Financial Responsibility for Dental Treatment* and return to:

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