Access Dental Care/Bill Milner, DDS, PA
125 South Park Street
Asheboro, NC 27203
Telephone: 336-626-7232 Fax: 336-625-5724
www.accessdentalcare.org

☐ New Patient
☐ Updated Patient
☐ Other: _____

CONSENT FOR DENTAL SERVICES

Access Dental Care, a not-for-profit organization, was founded to deliver dental care to special needs groups. Using state-of-the-art equipment, our staff provides on-site, comprehensive care to individuals who would have difficulty obtaining dental care in a traditional office setting.

Patient's Full Legal Name _____

☐ Female ☐ Male Date of Birth:_____ Soc.Sec.#:_____

Facility Name: _____ City_____

(Information of treatment provided will be shared with the facility.)

Person legally responsible for making treatment decisions:

Please check the appropriate box: ☐ **Resident** ☐ **POA** ☐ **Parent of a Minor** ☐ **Guardian***
* Guardianship Papers must be attached

Name: _____ **You must sign at the bottom of this form.**

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

You must check one of the boxes below for this form to be complete.

☐ I authorize Access Dental Care/BillMilner, DDS, PA to provide routine preventive diagnostic services which consist of an exam, x-rays and cleaning every 4-12 months. **If any additional treatment is recommended, I understand I will be provided with a treatment plan, written information about the treatment, and a consent form.**

Recommended treatment cannot be provided without your consent.

☐ I refuse all dental services. I will make arrangements with Dr._____for routine and emergency care.

_____ _____
Signature of Person Legally Making Treatment Decisions **Date**

This **MUST** be the same name in the box above, person legally responsible for treatment decisions.

Please fill out the form completely. A signature Is required on each side.

Revised Date 11/01/2011

Payment Information

☐ **MEDICAID**

►(to choose this option, a copy of the medicaid card must be attached)

Access Dental Care will electronically bill Medicaid directly for services.
Medicaid recipients will not be responsible for payment as long as the recipient is eligible on the date of service.

Medicaid Number:_____

☐ **DENTAL INSURANCE**

►(to choose this option, a copy of the front and back of the card must be attached)

Dental Insurance Subscribers Full Name: _____

Subscriber's Date of Birth: _____ Subscriber's SSN: _____

Bill Milner, DDS, PA will file your insurance claim and ask that payment be made to you. You will be responsible for paying the total due when you receive a statement from us. You will have to give consent for any treatment beyond exams, cleaning and x-rays. The treatment plan will give an estimate of charges. Pre-treatment estimates from your insurance company are available upon request.

☐ **PRIVATE PAY**

Any patient who does not currently have Medicaid or Dental Insurance (card provided) is Private Pay. Bill Milner, DDS, PA will send a billing statement after each dental appointment. You will have to give consent for any treatment beyond exams, cleaning and x-rays. The treatment plan will give an estimate of charges.

NOTE: Medicare does not have dental benefits

If the patient becomes *Medicaid* eligible you are responsible for notifying us. You will be financially responsible for any treatment that is provided before our office receives a copy of the patient's Medicaid card.

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Please complete the information according to where bills should be sent. You **must** sign this form below.

Name: _____Relationship to patient_____

Street: _____

City, State, Zip:_____

Home Phone_____Work Phone_____Cell Phone_____

Every patient is charged a facility visit fee to compensate for travel and set-up costs.
Prices may change without notice

I have read the above information and understand that I am responsible for payment of bills.
(No bill will be sent if Medicaid is the payment source for the treatment provided.)

_____ _____

Signature (This must be the signature of the person listed above who is to receive bills.) **Date**

Please fill out the form completely. A signature is required on each side.

Revised Date 11/01/2011