DEDICATED DENTAL SERVICE

Welcome to our practice! We know that you have a choice of Dental offices and we are happy that you have chosen us.
Our providers and staff are here to provide you with the most professional and compassionate care available. If you ever have any concerns regarding your care in our office, please do not hesitate to bring it to our attention immediately.

Our Mission is to provide you with exceptional dental care. We are also committed to having a mutually respectful relationship with each and every patient.

Financial Policy

We ask that payment be paid in full at the time services are provided, this includes co-pays and deductibles. Should there be any remaining balance assigned to you after the claims have been processed by your insurance company a billing statement will be mailed to the address we have on file.

Appointment Policy

We kindly request a 24-hour cancelation notice if you need to reschedule your appointment to avoid a $40.00 same day cancelation or missed appointment fee. Please keep in mind we are required to notify certain insurance companies if there is a history of missed appointments. Your courtesy will allow us to accommodate other patients. Thank you
Any services exceeding the amount of $1,000.00 will require a deposit to secure your appointment time.

Dental Insurance Policy

Dedicated Dental is contracted to provide services for numerous insurance companies and will file all claims to your insurance on your behalf, however we are not in a position to be 100% familiar with every different plan and its coverage, any fees that are given to you are just an estimate and not a guarantee of payment. PLEASE be familiar with the specific benefits of your dental insurance.

SIGNATURE_____ **DATE**_____

PRINTED NAME_____

801 N Wilmot Ste A-2	Mailing Addres	4001 S Mission Rd
Tucson, AZ 85711	P.O Box 26586	Tucson, AZ 85746
(520)750-1500	Tucson, AZ 85726	(520)573-1900

DEDICATED DENTAL SERVICE

AUTHORIZATION FOR TREATMENT OF MINOR PATIENTS

Please read throughly before signing.

Full Legal Name of Minor Patients:

First _____ Last_____ Date Of Birth ___ /___ /_____

First _____ Last_____ Date Of Birth ___ /___ /_____

First _____ Last_____ Date Of Birth ___ /___ /_____

I authorize the following adult individuals to accompany the above-mentioned patient(s) to the office of Dedicated Dental Service for the purposes of obtaining dental care. This dental care may include any treatment or diagnostic procedure the Doctors may see necessary.

Please also list parents:

Name _____ Relationship to patient_____Phone_____

Name _____ Relationship to patient_____Phone_____

Name _____ Relationship to patient_____Phone_____

Name _____ Relationship to patient_____Phone_____

Parent/Legal Guardian Signature _____ Date ___ /___ /_____

Printed Name _____

****** PLEASE be aware, a non-custodial parent, whose insurance covers any patient(s) will have full access to their Dental records even if this parent is not listed above.**