EXAMINATION NOTICE

Initial the following:

1. \_\_\_\_\_\_\_\_\_\_\_\_ I understand that I can choose to have dental hygiene services provided at a facility where dental care is not normally provided.
2. \_\_\_\_\_\_\_\_\_\_\_\_ I understand that all dental hygiene care provided by a collaborative practice dental hygienist will reduce future benefits that may be received from private insurance, Medicaid, or other third party provider of dental hygiene benefits for the remainder of the benefit period.
3. \_\_\_\_\_\_\_\_\_\_\_\_ I understand that services rendered by a collaborative practice dental hygienist are billed through a collaborative practice dentist and I may receive a bill from said dentist if services are not paid in full by private insurance, Medicaid, or other third party payers.
4. \_\_\_\_\_\_\_\_\_\_\_\_ I understand that balances are collected at time of service and that the dental hygienist may collect the full fee, partial fee, co-pay, and/or deductible when they apply and that all insurance benefits are calculated as an estimate and are not a guarantee of payment.

The dental hygienist provided this examination notice to inform \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print name) that suspicious lesions are present on the hard or soft tissues in the oral cavity and is recommending an appointment with a dentist within the next thirty (30) days for examination and consultation for treatment options.

Date:

Print:

Sign:

Dental hygiene services do not constitute a comprehensive dental diagnosis. Failure to follow-up with an examination notice form may result in increased dental disease and eventual tooth loss for which the patient will be responsible.

Date:

Print:

Sign: