

Treatment Plan

Patient Name: _____

Denture Treatment Plan:

Estimated Cost: _____

Patient Consent:

I have been informed of my treatment options, including estimated costs and I understand what has been presented to me.

I accept the treatment plan and give permission to _____ to provide me the services as presented and accepted in this form. I also give my consent to any advisable and necessary denture procedures by the attending dentist or by their supervised staff for denture treatment.

I understand and accept responsibility for and agree to pay all fees associated with my treatment. My insurance coverage or lack of insurance coverage will not release me of my responsibility to pay for the agreed upon treatment. I understand the treatment estimate presented to me is an estimate. There may be a need to modify treatment. In such a case, I will be informed of the need for additional treatment, and its fee.

Patient Signature: _____ **Date:** _____

Denturist Signature: _____ **Date:** _____

| Try In Accepted | Teeth | Maxillary | Mandibular |
|--------------------------------------|------------|-------------|-------------|
| Patient Signature: _____ | Anteriors | Shade _____ | Shade _____ |
| | | Mould _____ | Mould _____ |
| Denturist Signature: _____ | Posteriors | Shade _____ | Shade _____ |
| | | Mould _____ | Mould _____ |

Date: _____

Comments: _____
