PLEASANT DENTAL

Welcome to our Office

Office Policy & Insurance Information

On your first visit, you will be greeted by our staff and asked to fill out a few forms detailing your medical history as well as any concerns you may have about your dental health. This form has been provided on our website, allowing you to have it ready prior to your appointment.

During your consultation, Doctor Lotfi will examine your mouth and discuss any concerns you may have. At that time we will also outline a treatment and financial plan that will best fit your needs. Pleasant Dental has a 24-hour cancellation policy and there is a $50 fee for a broken appointment.

Payment Options

Patients Without Insurance:
We expect payment in full at the time of service.

Patients With Insurance:
We recommend obtaining a predetermination of your dental benefits from your insurance company before starting treatment. Some services we provide are deemed cosmetic by insurance carriers and therefore may not be covered by your policy.

Patients may choose to pay the total amount at the beginning of treatment, just as if they did not have insurance. This will allow you to take advantage of the 5% savings on the fee for your treatment. We will assist you in recovering any insurance benefits.
Or, you can pay your estimated portion, based on the predetermination of your benefits, at the time of treatment. After your insurance has been billed and payment received any balance will then be due.

Office Policy & Insurance

I have read and agree to be bound to all the above office policies. I understand that I am responsible for payment of all services rendered by Dr. Lotfi and staff at the time of treatment, unless prior arrangements have been made. I am responsible for any co-payment and deductibles my insurance doesn't cover. I agree to pay in full for any procedure not covered by my insurance or for any procedure my insurance reduces coverage due to their alternative benefit policies.
I authorize my insurance benefit payment to go directly to Pleasant Dental.
I authorize Dr Lotfi to release all examination and treatment records to my insurance company.

The above information is true to the best of my knowledge.
I have read and agree to be bound to all the above office policies.

Dental Insurance Company: ______________________
Insurance Company Address: ______________________
____
Phone : ______________________
Group #: ______________________

Policy holders name: ______________________
Social security #: ______________________
Birth date: ______________________
Employer: ______________________

Signed: ______________________ Printed name: ______________________ Date: __________