EASTSIDE
DENTAL MEDICINE
The Center for Advanced Cosmetic and Implant Dentistry

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Where skillful dentistry, health, beauty, and luxury converge

AUTHORIZATION FOR TREATMENT

The enclosed recommendations are necessary to restore your mouth to a good level of health. This is an estimate and does not reflect the exact costs that may be incurred for the following reasons:

- Additional cavities are sometimes detected as other work is being completed.
- A tooth that apparently needed a small filling may need a more complex one such as root canal therapy, post/cores, crowns, etc.
- Check-ups and cleanings provided on a 6 or 3 month cycle.

All dental and anesthetic procedures have associated risks. These may be, but are not limited to:

- Drug reactions and side effects
- Damage to adjacent teeth or fillings
- Bruising, swelling, sensitivity, or pain.
- Failure of the dental procedure necessitating additional treatment.
- Complications during treatment necessitating referral to a specialist.

The estimate will give you a good idea as to the condition of your mouth and the approximate costs of having the work completed. The exact cost will be based on the work done and the fees that are routinely charged.

We will be more than happy to set a payment plan and will submit insurance papers on your behalf for your reimbursement.

I hereby authorize Dr. Srivastava, Dr. Castracane and their Associates to perform the dental work outlined in the Treatment Plan indicated.

I understand the recommended treatment for my conditions, the risks of such treatment, any alternatives and risks, as well as the consequences of doing nothing. Any fee(s) involved have also been explained. All of my questions have been answered, and I have not been offered any guarantees.

Signature of Patient, Parent or Guardian **Date**

Witness

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