Professional Center of Dental Care
433 North Bolingbrook Dr.
Bolingbrook, IL 60440

Dear Patient,

Welcome to our office and thank you for selecting our staff as your dental health team. It is the policy of this office to render the highest quality, preventive oriented dentistry available today. Our staff consists of general dentists, hygienists and an orthodontist. We have employed these professionals with the intention that most of your dental needs may be met in this single office setting. We will do our best to alleviate your dental fears and make your visit as comfortable as possible.

Patients are seen on an appointment basis. The appointment you schedule is **reserved strictly for you.** When it becomes necessary for you to change or cancel an appointment, it is expected that at least 24 hour notice be given to this office. Failing to comply with this request will result in a **charge**. Emergency appointments will be scheduled as soon as possible.

Payment is expected at the time services are rendered. For those patients who have dental insurance, we will assist you in processing your dental claim but we do request a partial payment at the time of treatment as no dental insurance pays 100% of all the dental treatment. We will make payment arrangements, if the need arises. We would appreciate your cooperation in these matters.

We will need to make a copy of your driver's license or state identification card in order to prevent fraud and/or identity theft.

Your dental health is our main concern, if you have any questions regarding dental treatment or financial arrangements, please do not hesitate to speak to any member of our staff.

AUTHORIZATION

I hereby authorize payment of dental benefits, otherwise payable to me, to the Professional Center of Dental Care. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/ or other health professionals.

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Patient Name

X____
Signature of Patient or Responsible Party

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Date