DELTA DENTAL

Non-Covered Services Patient Consent Form

This section to be completed by the Dental Office.

Office Name	Provider Name
Office Phone Number	Date Treatment Plan Created

*This signed form is required to be kept as part of the member's dental chart.

Procedure(s)	Tooth/Arch	Fee
		$
		$
		$
		$
		$
		$
		$
		$
	Total Fee	$

This section to be completed by the member, parent or guardian.

Member ID	Member Name
Signed By Name (*Member, Parent or Guardian)	

Respond YES or NO to each statement below.

☐ Yes ☐ No My dentist advised me that there are **NO** covered services to take care of my dental concern.

☐ Yes ☐ No My dentist advised me that there **ARE** covered services that would take care of my dental concern, but I am refusing covered services to select these.

☐ Yes ☐ No I understand I have to pay the total amount for any of these services and that **Delta Dental will not pay** any portion of the cost.

***I agree to pay for these dental services. If I fail to make each payment I may be subject to collection action.**

*Patient's Signature if over eighteen (18) or Parent or Guardian	Date