Foxboro Dental Associates Inc
Victor Leung, DMD
Kevin Duong, DMD
Benjamin Tubo, DMD
132 Central Street, Suite #103, Foxboro, MA 02035
Tel (508) 543-7901

www.foxborodental.com

Dear,

On behalf of the whole Foxboro Dental Associates team, we welcome you to the practice.

Serving Foxboro and surrounding communities since 1962, our mission statements below reflect a continued commitment to our patients.

Our first priority is to you, the patient.
We will never compromise patient care.
Our obligation is to present all treatment options to our patients.
We strive for 100% in quality.
We expect nothing less than our best effort each day.
We will strive to deliver outstanding customer service.

In summary, we strive to foster patient relationships based on mutual trust, excellent customer service and the best patient care available.

- Office hours are

Monday	7:00 am – 7:30 pm
Tuesday	7:30 am – 4:30 pm
Wednesday	7:30 am – 4:30 pm
Thursday	7:00 am – 7:30 pm
Friday	8:00 am – 2:30 pm
Closed for Lunch	1:00 pm – 2:00 pm except Fridays

- Patients of record with a dental emergency after hours can call and speak with one of our on call dentists.

- With regards to Broken Appointments, please be advised that we ask for at least 48 hours notice of your need to change your appointment. Should we not hear from you at least 48 hours prior to your appointment, there will be a $52 charge.

- As a ***courtesy*** to our patients, we will submit for services rendered, to dental insurance companies on ***your*** behalf. Your dental insurance status is typically updated on the day of your visit. Co-payments are calculated and collected at time of service unless alternative arrangements have been made. Our patients are responsible informing the office of changes to their dental insurance coverage. Ultimately our patients are responsible for services not covered by their dental insurance.

- Payment is expected at time of services rendered. Acceptable methods of payment include cash, check or credit card. Third party financing including interest free options are available.

- Returned or bounced checks are subject to a $25 fee.

- During the winter months in the event of snow, the practice will make every effort to contact you should the office need to close.

- For more information visit us at www.foxborodental.com.

Practice Administrator**:**_____Date**:** _____

Patient Signature**:**_____Date: _____

Foxboro Dental Associates Inc.

General Dentistry Informed Consent

1. Dental Treatment; I understand that I may have any of the following treatment done which include but are not limited to: fillings, bridges, crowns, extractions, root canals, dentures, x-rays, cleanings, scaling and root planings, implant restorations, etc.

2. Medications and Prescriptions; I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. In very rare instances, local anesthesia ("novacaine") can cause parasthesia (discomfort in the nerves of the mouth, jaw etc.) or even permanent anesthesia.

3. Changes in Treatment Plan; I understand that during treatment it may be necessary to change or add procedures because of conditions found while treating the teeth which were not discovered during the examination, I.e. root canal therapy following routine restorative procedures. I give my permission to the dentist to make any and all changes and additions as necessary for the best of my care.

4. Dental Insurance; I understand that it is **my responsibility** to have the correct dental insurance information. I understand that I need to inform Foxboro Dental Associates of any changes to my insurance. I understand that Foxboro Dental Associates will submit claims as a courtesy to me.

5. General; I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I hereby authorize the doctors at Foxboro Dental Associates and the dental auxiliaries to proceed and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on the unforeseen or un-diagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

I understand that this agreement is to verify that I wish to be treated by Foxboro Dental Associates Inc.

Patient Name : Date:_____

Signature:_____ Date:_____

Guardian if minor:_____ Date:_____

Print guardian's name:_____ Date:_____