HAYES
GENERAL & COSMETIC DENTISTRY

Non-Covered Services Dental Consent Form

I, _____, understand that some services may not be considered eligible to be covered by my dental benefits (e.g., services and/or supplies may be determined to not be dentally necessary, non-covered or investigational) by my dental insurance provider. I understand that my dental insurance coverage has certain restrictions and limitations, such as authorization requirements, waiting periods, as well as non-covered services. **Examples of these may include, but are not limited to:**

- Adult Fluoride
- Porcelain Crowns
- Porcelain Margins on Crowns
- Resin Filings
- Bone Graft
- Nitrous Oxide Inhalation Analgesic
- Arestin (Anti-Microbial Agent)
- Lab Fees
- Mouth Guards or Occlusal Splints
- X-Rays (not covered due to frequency)

I understand that I am financially responsible for any and all related charges if they are not covered by my dental insurance.

Signature of person Financially Responsible Date