Proposed Treatment Plan for ____ (Patient Name)

The following proposed treatment plan was developed during an oral examination performed on ______________________(date).

- ☐ As the responsible party, please review this document and contact us to discuss treatment recommendations.
- ☐ Further treatment needs to be determined following radiographic (x-ray) evaluation. Cost: $__________________

The following treatment is recommended:

- ☐ Please see accompanying Oral Care Plan.
- ☐ Oral examination and denture evaluation every 6 months. Cost: $__________________ per exam.
- ☐ Oral examination and teeth cleaning every ________ months. Cost: $______________ per oral examination and teeth cleaning.
- ☐ Extractions of retained tooth roots #'s: ____
  - Cost: $_______________ per retained tooth root x ________ retained tooth roots = $________________
- ☐ Extractions of teeth #'s: ____
  - Cost: $_______________ per tooth x ___________ teeth = $ ____________________
- ☐ Restoration of teeth #'s: ____
  - Cost: $_______________ per tooth x ___________ teeth = $ ____________________
- ☐ Crowns on teeth #'s: ____
  - Cost: $_______________ per tooth x ___________ teeth = $ ____________________
- ☐ Rebase of dentures or partials (recommended every 3 years): UPPER (denture partial) LOWER (denture partial)
  - Cost: $_______________ per prostheses x ______________ prostheses = $ ______________________________
- ☐ Construction of dentures or partials: UPPER (denture overdenture partial) LOWER (denture overdenture partial)
  - Cost: $_______________ per prostheses x ______________ prostheses = $ ______________________________
- ☐ Other: ____

  ____
  - Cost: $____________________________________

Billing policy: This is an estimate only and prices are subject to change without notice. As the responsible party, a bill will be sent to you for full payment. All procedures are billed on the date initiated and payment is expected when services are billed. Dr. Ghezzi is not a participating provider with any dental insurance plan; however, many insurance plans will still pay a partial benefit for services rendered. As a service to you, we will submit claims to the dental insurance company provided to us. The insurance reimbursement will be paid directly to the insured and payment is due in full regardless of insurance reimbursement. Please be sure that you have provided us with the most up to date dental insurance information.

To ensure regular oral care and as a courtesy to you, a regular oral examination/cleaning recall schedule is maintained. Please contact us at 734-358-0275 if you have any questions about dental care for your loved one. Thank you for the opportunity to provide quality dental care to your loved one.

Signature: ____ Date: ______________________

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