SENIOR DENTAL CARE, LLC
801 Technology Dr., Suite D
Little Rock, AR 72223

Family Consent Form

Residents Name: _____ Facility Name: _____

I agree to pay for the exam marked below for my loved one.

☐ Basic Initial Exam (Patient of no records, radiographs, or tooth charting):

New Patient Exam	$ 46.00
Full Mouth Radiographs (10+ x-rays)	$ 95.00
Prophy (Basic Cleaning)	$ 53.00
Fluoride Application	$ 25.00
Total	$ 219.00

☐ Re-Care Exam (Patient of record, radiographs and tooth charting):

Follow Up Exam	$ 29.00
Prophy (Basic Cleaning)	$ 53.00
Fluoride Application	$ 25.00
Total	$ 107.00

☐ Brief Pain Exam (Resident with a certain issue to exam)

Problem Focused Exam	$ 38.00
Single X-Ray	$ 20.00
Total	$ 58.00

If the brief pain exam is selected, I will pay up to $ _____, for any treatment that can be completed on the day the exam is completed.

Printed Name Signature

Date_____

Please fax this form to: 501-821-4311