Bond County Health Department

1520 South 4th Street
Greenville, Illinois 62246

Phone: (618) 664-1442 Fax: (618) 664-1744

THE FOLLOWING POLICIES ARE IMPORTANT TO ALLOW US TO PROVIED YOU WITH THE BEST POSSIBLE DENTAL CARE AND COMPLETE YOUR TREATMENT IN A TIMELY MANNER.

_____ Please have a current insurance card and valid identification (driver's license) at **EACH** visit.

_____ Our goal is to help you have good oral health. Therefore, we require each patient receive a dental cleaning and x-rays from a dental hygienist before beginning any treatment with the dentist. **(MOST ADULT CLEANINGS ARE NOT COVERED BY IL DEPT. OF PUBLIC AID MEDICAL INSURANCE)**

_____ It is important that you follow the dental staff's care instructions between visits.

_____Your hygienist will discuss with you the importance of regular visits to our clinic (usually every 6 months) for a cleaning and examination. THESE VISITS WILL HELP PREVENT PAINFUL DENTAL PROBLEMS IN THE FUTURE.

_____IT IS THE RESPONSIBILITY OF THE PATIENT TO PROVIDE CURRENT CONTACT INFORMATION. CONFIRM YOUR APPOINTMENT. You will receive a reminder call 1-2 days prior to your appointment date. We must have verbal confirmation that you are keeping your appointment. **APPOINTMENTS NOT CONFIRMED 24 HRS BEFORE THE APPOINTMENT WILL BE CANCELED.**

_____Please arrive 10 minutes before your appointment to allow is the check you in. In order to respect our other patients, you may be rescheduled to a later date if you arrive past your appointment time. We will strive to see you at your appointment time, except where other emergency or problem cases interfere.

_____**24 HOUR NOTICE PRIOR TO CANCELLATION IS REQUIRED.** After the **FIRST** missed appointment there will be a 6 month waiting period before scheduling a second appointment. After **TWO** missed appointments by an individual/family, you will be required to pay a **$20** fee before receiving any treatment at your next appointment. A **THIRD** failed appointment will prevent you from receiving dental treatment in our clinic. You will received notification by mail if we find it necessary to take this action. We receive the right to decide if this policy can be waived for special situations.

By initialing and signing, I agree I understand the above listed policies and accept my responsibility to follow them in order to have a successful dental health partnership with Bond County Health Department Dental Clinic.

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Name **Date**