



## **Otis R. Washington, D.D.S., M.S., P.A.**

*Diplomate of the American Board of Periodontology*

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2310 Myron Drive  
Raleigh, North Carolina 27607  
(919) 782-9536  
(919) 782-9962 fax

### **IMPORTANT INFORMATION FOR OUR PATIENTS**

#### **APPOINTMENTS**

Our appointments are scheduled to respect your time. We reserve a specific time for your care and we make every effort to see you at that appointed time. We appreciate your promptness and consideration in not changing your scheduled time. However, if you do need to change an appointment, a *48-hour notice is required*.

#### **MEDICAL HISTORY**

Please fill out the medical history and bring to our office on your first visit.

#### **PICTURE ID**

New guidelines require that we verify identification of new patients. Please have a photo ID available.

#### **RADIOGRAPHS**

A full mouth series of radiographs is necessary for our office to make an accurate evaluation. Please make every effort to bring these or have your general dentist forward us a copy. Most insurance companies will pay for a full mouth series every 3 to 5 years. If we do not have access to these we will take them and you will be responsible for payment.

#### **PERIODONTAL PROBING**

Please bring your latest periodontal probing (if available) from your general dentist or have it forwarded to our office.

#### **PAYMENT OPTIONS**

For your convenience, we accept Visa, MasterCard, Discover, American Express, personal checks as well as Care Credit.

#### **DENTAL INSURANCE**

We are glad to assist you in obtaining the maximum benefit from your dental insurance plan. Once your plan has been verified, we will accept assignment of payment from your insurance company. Most plans cover a portion of the dental fee, which means you will be responsible for your deductible and the portion we estimate your plan will cover. Payment of your portion is expected at the time you are in our office for dental care. If your insurance company does not pay the estimated portion you are responsible for the services you have received. Please have your insurance card available.

**I understand that I am responsible for any debt from services rendered.**

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**Patient or Guardian**

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**Date**