Today’s Date: \_\_\_/\_\_\_/\_\_\_\_\_\_

This is our policy concerning radiographs (X-Rays). What are the guidelines? We base our decision to take radiographs n the recommendations of the ADA and standard of care as defined in Florida and the United States. Radiographs are the only way to diagnose bone loss, cavities between and within the teeth, bone lesions, bone cancer, root tip infections (abscess) that would require endodontic (root canal) treatment amount other things. Absence of pain is not an indicator that there is not an active infection present in the teeth or bone. Often, we see small problems with radiographs and treat them before it becomes a more significant one. We use digital radiography which uses a much lower dose of radiation than the traditional film-based systems. As a result, we have significantly reduced the exposure to our patients and staff.

In addition, the digital system allows us to magnify the images and more clearly see problems thus aiding our ability to diagnose. As a patient of Joseph Salas DMD we need to have a current full mouth series of radiographs. If you have a copy from your previous dentist, they need to have been taken within the last two years ad be of diagnostic quality. If the copy is blurred or of poor quality a new set will be taken at the cost of the patient.

It is Joseph Salas DMD’s policy to do an annual exam on all patients. During this exam with the doctor, x-rays (4 bite-wing) will be taken to meet the standard of care. In addition, Dr. Salas requires a full mouth series be taken every three years. If you do have dental insurance, your policy may or may not cover this, that which is not covered by insurance will be considered the patients portion.

Thank you for your corporation in helping us to provide you with excellent quality care.

I have read and agree to the terms listed above regarding dental radiographs.

Printed Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_