

Oral & Maxillofacial Surgical Specialists

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TENNCARE WAIVER OF LIABILITY

I _____ have been made aware that my insurance will not cover the following services and that I am responsible for all charges incurred relating to these services:

- Exam – Plan frequency limitation (1) Dental exam allowed every (6) months.
- X-ray – Plan frequency limitation (1) Panorex x-ray allowed within a (3) year period.
- Extractions of non-abscessed teeth
- Cardiac Monitor
- Hemoglobin
- Facial Ice pack
- General Anesthesia
- IV Sedation
- Alveoloplasty
- Operculectomy
- Occlusal X-ray
- _____ Other

I have been given an itemization of my proposed treatment plan; therefore, I acknowledge and recognize my responsibility for these charges.

Patient/Guardian if Minor

Date

Witness

Date