



DUNWOODY DENTAL
5030 West SR 46, Suite 1018
Sanford, FL 32771
407-328-9492

I have chosen to upgrade the quality of lab and /or services that are not provided for, under my insurance plan.

Date: _____

Patient Name: _____

Treatment: _____

Fee to Upgrade: _____

Total Fee: _____

Patient (Guardian) Signature: _____

Team Member Signature: _____

By signing this document you are agreeing to an upgrade of treatment. We are contracted as a PPO provider, however, if you choose to upgrade your treatment, you will be responsible for the balance that the upgrade entails.