

**MAINE CENTER FOR DENTAL MEDICINE
X-ray Policy**

Dental x-rays provide one of the best diagnostic tools in dentistry. They enable the dentist and hygienist to see inside the tissue of the teeth, gum disease and bones of the jaw and overall composition of facial bones. X-rays help the dentists to see diseases of the teeth, gums and surrounding tissue that cannot be seen with a basic visual oral examination and help them find and treat dental problems early in their development – thereby saving you money, time, discomfort and possibly your life.

We assure you that we are conservative in our use of x-rays, but without them, decay and other diseases of the teeth and mouth often cannot be diagnosed until serious damage has been done. We never take unnecessary x-rays.

While dental patients have the right to refuse x-rays, the dentist also has the right to set a policy dictating how they intend to use x-rays to improve their practices and the health of their patients.

Maine Center for Dental Medicine recommends that x-rays be taken at regular intervals for patients with no signs of decay or disease, and for diagnostic purposes when indicated. A cone beam CT scan maybe needed every three to five years, as well as bitewing x-rays every 12 months.

If you have been seen by a dentist within the last five years and have had x-rays taken, it is important that we receive copies of these from your previous dentist. If they are of good quality, it may not be necessary to have them taken at your first visit with our office.

Some dental insurance plans have limits on their coverage of x-rays. If you have dental insurance, please check your policy's coverage. Good, quality x-rays taken at your previous dentist may be used by our office. You may email x-rays and dental records to: info@mainecdm.com. If x-rays sent are of poor quality, or if we do not receive them from your previous dentist before your first visit, we will require new x-rays be taken. You may be responsible for the fees involved, as insurance may not cover these fees.

I hereby agree to this x-ray policy.

Printed Name

Doctor

Signature

Doctor Signature

Date: _____