



SureSmile[®] Aligner

Don't wait to get the smile
you've always wanted.

Patient Name _____ Date _____

Diagnostic Records: Includes patient photos, panoramic and cephalometric radiographs, digital impressions, and digital models. (Value \$_____)

SureSmile[®] Treatment _____

Less Event Discount (when applicable)

Less Estimated Insurance
(Insurance estimate is not a guarantee of payment. If for any reason your insurance does not pay it becomes your obligation.)

Patient Estimated Cost _____

Please be aware financing options are subject to change at the discretion of the dental practice.



Payment Options

Option A: Payment in Full - Cash (additional ____% off) _____

Option B: Payment in Full - Credit Card (additional ____% off) _____

Option C: Payments over time w/down payment

Down payment _____

Number of Months for balance _____ months

Monthly payment amount _____ /month