In Case Of Emergency Please Call:

Name: _____ Relation: _____

Phone Number (s): _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that the information will be held in the strictest confidence, in compliance with Federal and State policies, and it is my responsibility to inform the Dental Office of any changes to my medical status.

Signature of Patient or Guardian Date

Payment is due in full at the time of treatment
Unless prior arrangements have been made

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance company does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company and dental health care providers.

Signature of Patient or Guardian Date

OFFICE POLICY FOR CHANGED OR CANCELLED APPOINTMENTS:

WE REQUEST A 48 HOUR NOTICE FOR ANY CHANGE TO SCHEDULED APPOINTMENTS