

WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

1. Personal Information

Date _____

Birthdate _____

SS#/SIN _____ Email _____

Name _____

Wishes to be called _____

Male Female Minor Single Married Divorced Widowed Separated

Address _____

City _____ State/Prov. _____ Zip/P.C. _____

Employer _____ Occupation _____

Referred by _____

2. Responsible Party

Who is responsible for the account?

Name _____

Relationship to patient _____

Birthdate _____ Driver's License # _____

SS#/SIN _____ E-Mail _____

Address _____

City _____ State/Prov. _____ Zip/P.C. _____

Employer _____

Occupation _____

Work Phone _____ Ext. # _____

Home Phone _____ Cell Phone _____

3. Telephone

Home Phone _____ Work Phone _____ Ext. # _____

Cell Phone _____

Where do you prefer to receive calls? Home Work Cell

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Work # _____ Home # _____

4. Dental Insurance Information

Primary Insurance

Name of Insured _____
Relationship to patient _____
Insured's birthday _____
SS#/SIN _____
Employer _____
Date Employed _____
Occupation _____
Insurance Company _____
Group # _____
Policy/ID. # _____
Ins. Co. Address _____
Ins. Co. Phone # _____

Additional Insurance

Name of Insured _____
Relationship to patient _____
Insured's birthday _____
SS#/SIN _____
Employer _____
Date Employed _____
Occupation _____
Insurance Company _____
Group # _____
Policy/ID. # _____
Ins. Co. Address _____
Ins. Co. Phone # _____

5. Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or Dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Signature of patient or parent/guardian if minor

Date

6. Financial Arrangements

For your convenience, we offer the following methods of payment.

Please check the option which you prefer.

Payment in full at each appointment.

_____ Cash

_____ Personal Check

_____ Credit Card (Visa, MC, Discover AmExp.)

_____ I wish to discuss the dental office's policy.

Late Charges

If you do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in your being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount of any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help.

HEALTH HISTORY

NAME _____ BIRTHDATE _____ TODAY'S DATE _____

PHONE # _____ (HOME) _____ (CELL) _____ (WORK)

A Dental History

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <p>1. Reason for visit: _____</p> <p>2. When was your last dental visit? _____</p> <p>3. How often do you brush your teeth? _____</p> <p>4. What texture brush do you use? <input type="checkbox"/> Soft <input type="checkbox"/> Medium <input type="checkbox"/> Hard</p> | <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;">YES</td> <td style="width: 50%; text-align: center;">NO</td> <td style="width: 50%;"></td> <td style="width: 50%; text-align: center;">YES</td> <td style="width: 50%; text-align: center;">NO</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>14. 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| YES | NO | | YES | NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <input type="checkbox"/> | <input type="checkbox"/> | b. Oral surgery? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <input type="checkbox"/> | <input type="checkbox"/> | d. Your teeth ground or the bite adjusted? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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B Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important inter-relationship with the dentistry that you will be receiving. Thank you for answering the following questions.

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--------------------------|--------------------------|-----------|----------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|---|--|--|--|--|--|---|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------------|--|--|---|--|------------|-----------|--|--------------------------|--------------------------|--|--------------------------|--------------------------|---|--------------------------|--------------------------|---|--------------------------|--------------------------|-----------|--------------------------|--------------------------|---------|--------------------------|--------------------------|---|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%; text-align: center;">YES</td> <td style="width: 50%; text-align: center;">NO</td> </tr> <tr> <td>1. Are you in good health?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>2. Have there been any changes in your general health within the past year?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>3. Date of your last physical exam: _____</td> <td></td> <td></td> </tr> <tr> <td>4. Physician's name _____
Address _____
Phone Number _____</td> <td></td> <td></td> </tr> <tr> <td>5. Are you now under the care of a physician?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>6. Have you ever been hospitalized for any surgical operation or serious illness?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Please explain: _____
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If yes, what medicine(s) are you taking? _____
_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>8. Have you ever taken Fen-Phen/Redux?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>9. Have you ever taken any of the following medications: Bisphosphonates (osteoporosis medications) including Actonel, Boniva, Reclast, Zometa, Didronel, Fosamax, Skelid, Aredia, Bonafos?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>10. Have you taken Cortisone or Steroids?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td> a. Lotion</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td> b. Oral</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>11. Have you had any abnormal bleeding?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>12. Do you bruise easily?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>13. Have you ever required a blood transfusion?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>14. Have you had a recent weight loss?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> | | YES | NO | 7. Are you taking any medicine(s) including nonprescription medicine/vitamins/herbal supplements?
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_____ | <input type="checkbox"/> | <input type="checkbox"/> | 8. Have you ever taken Fen-Phen/Redux? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Have you ever taken any of the following medications: Bisphosphonates (osteoporosis medications) including Actonel, Boniva, Reclast, Zometa, Didronel, Fosamax, Skelid, Aredia, Bonafos? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you taken Cortisone or Steroids? | <input type="checkbox"/> | <input type="checkbox"/> | a. Lotion | <input type="checkbox"/> | <input type="checkbox"/> | b. Oral | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you had any abnormal bleeding? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you bruise easily? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever required a blood transfusion? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Have you had a recent weight loss? | <input type="checkbox"/> | <input type="checkbox"/> |
| | YES | NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Are you in good health? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. Have there been any changes in your general health within the past year? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. Date of your last physical exam: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. Physician's name _____
Address _____
Phone Number _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. Are you now under the care of a physician? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Please explain: _____
_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | YES | NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. Are you taking any medicine(s) including nonprescription medicine/vitamins/herbal supplements?
If yes, what medicine(s) are you taking? _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. Have you ever taken Fen-Phen/Redux? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. Have you ever taken any of the following medications: Bisphosphonates (osteoporosis medications) including Actonel, Boniva, Reclast, Zometa, Didronel, Fosamax, Skelid, Aredia, Bonafos? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. Have you taken Cortisone or Steroids? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. Lotion | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. Oral | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. Have you had any abnormal bleeding? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12. Do you bruise easily? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13. Have you ever required a blood transfusion? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. Have you had a recent weight loss? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

(over)

- | | YES | NO |
|--|--------------------------|--------------------------|
| 15. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you use tobacco (smoking, snuff, chew)?
If yes, how interested are you in stopping?
Very / Somewhat / Not interested | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. How long have you used tobacco for and what quantity? _____
(circle one) | | |
| 18. Do you drink alcoholic beverages?
Are you alcohol dependent? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you use drugs or other substances for recreational purposes or have you in the past?
If yes, please list: _____
Frequency of use: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you wear contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you have any disease, condition or problem not listed above that you think we should know about? | <input type="checkbox"/> | <input type="checkbox"/> |

Women Only:

- | | | |
|---|--------------------------|--------------------------|
| 1. Are you pregnant or think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |

Are you allergic to or had reactions to:

- | | | |
|---|--------------------------|--------------------------|
| 1. Local anesthetics like novocaine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Penicillin or other antibiotics? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Sulfa drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Barbiturates, sedatives, sleeping pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Aspirin? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Metals? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Latex? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Codeine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Other? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Do you have or have you ever had the following:

- | | | |
|--|--------------------------|--------------------------|
| 1. Rheumatic heart disease or rheumatic fever? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Scarlet fever? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Heart defect or heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Heart trouble, heart attack, or angina? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Do you have pain in your chest upon exertion? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | YES | NO |
|---|--------------------------|--------------------------|
| b. Are you ever short of breath after mild exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Do your ankles swell? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Do you get short of breath when you lie down? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Pacemaker? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Heart surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. High blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Low blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Hepatitis, jaundice, or liver disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Stroke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Sinus trouble? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Lung or breathing problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Asthma or hay fever?
Do you carry an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Hives or skin rash? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Fainting spells or seizures? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Diabetes?
Type I / Type II | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. AIDS or HIV infections?
Viral Load? _____ CD4 count? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Thyroid problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Arthritis or rheumatism? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Joint replacement or implant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Stomach ulcer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Kidney trouble? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Tuberculosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Persistent cough? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Cough that produces blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Sexually transmitted disease?
If yes, Please list: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Anemia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Leukemia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Glaucoma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Acid reflux/persistent heartburn? | <input type="checkbox"/> | <input type="checkbox"/> |

Do you have any disease, condition, or problem not listed above that you think we should know about? _____

If yes, Please explain: _____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? _____

If yes, what antibiotic and dose? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

DATE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT



I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason

PRACTICE FINANCIAL ARRANGEMENT FORM



We are committed to providing you with the best possible dental care and are pleased to discuss any and all of our professional fees at any time. Your clear understanding of our Financial Arrangement Form is very important to our professional dental relationship. If you have any questions or concerns, please ask one of our qualified team members.

We request that you settle your account by paying for treatment at the time service is rendered. For your convenience we accept Cash, Personal Checks, Visa, MasterCard, & Discover.

Insurance — Your insurance benefits are determined by your employer, not your dentist. Insurance is not a guarantee of payment; they will not pay for all of your costs. Your insurance policy is a contract between you and your insurance company. Your insurance and personal payment portion is still your responsibility. As a courtesy we will file your insurance claim for you if you bring: 1) your dental insurance wallet card and 2) all required employer information. If our office is unable to verify your insurance information before treatment, you will be expected to pay for services in full on the day of your visit. If payment for previous services has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible.

Financial Arrangements — Financial arrangements must be determined before any treatment begins & will only be extended to patient(s) having major comprehensive dental treatment. Fees and timeframe will be discussed prior to beginning treatment. We have several options available which will be discussed when you meet with a treatment coordinator.

New Patient / Urgency Appointments — We will be happy to make an appointment for you to take care of your treatment needs. For these specific types of appointments, payment will be collected IN FULL at the time of service until you are established in our practice as a participating patient. Once established, regular payment policies will apply.

Broken Appointments / Short Notice Cancellations — A phone call and/or letter will be extended to patients who do not show for their appointment. The first broken appointment - a warning will be given stating the procedure that will be followed in the future. At the second consecutive broken appointment, a \$50.00 fee will be assessed to your account. Appointments are reservations made for you, therefore, we request a 24 hour notice if you are unable to keep your scheduled appointment.

We reserve the right to charge and collect fees for appointments that are cancelled or broken without 24 hours advance notice. Appointments are reserved exclusively for you. If cancelled or broken, the time is taken away from other patients who are waiting to be placed in our schedule.

PRINTED NAME

SIGNATURE

DATE