APPOINTMENT CONFIRMATION

To help patients remember their appointments which have been reserved exclusively for them and also to provide the opportunity to clear up any questions regarding the procedure(s) to be performed, we have found that it is best to personally confirm appointments two business days before the scheduled time but no later than 11:00 am the business day preceding. Please keep in mind that Monday through Thursday are our business days; therefore, a Monday appointment needs to be confirmed the preceding Wednesday, but no later than 11:00 am on Thursday. Hence, the purpose of this section is to determine the best method of confirming your appointment. Please indicate your preferences below.

A. REGARDING CONFIRMING APPOINTMENTS (Please mark your preference)

☐ 1. I will call two business days before my appointment to confirm.

☐ 2. I wish to be called and reminded of my return appointment.
I can be reached at:
*Home # _____ . Best time to call: _____ .
*Work # _____ . Best time to call: _____ .
*Other # _____ . Best time to call: _____ .
**Memo* _____ .

Would you approve of appointment confirmation as early as 7:00 am and as late as 8:00 pm? .... ☐ Yes ☐ No
Would you approve of some of your appointments being confirmed by computer? ..... ☐ Yes ☐ No
If so, e-mail address: _____

B. REGARDING UNCONFIRMED APPOINTMENTS (Please mark your preference.)

☐ 1. I want you to keep my appointment time reserved for me even though you may not be able to reach me or I have not called to confirm by 11:00 am the business day preceding the appointment. I understand if I don't keep my appointment there is a fee for broken appointments and late cancellations (less than one business days' notice).

☐ 2. I DO NOT want you to keep my appointment time open for me if you are unable to confirm it or have not heard from me by 11:00 am the business day preceding my appointment. I will call to reschedule my appointment on another day. I understand if I confirm my appointment and then fail to keep my appointment there is a fee for broken appointments and late cancellations (less than one business days' notice).

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the dental needs of:
(name of patient) _____ .

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1½% late charge (18% APR) may be added to my account. I also understand that insurance is filed as a courtesy and I am responsible for the full amount of treatment in the event insurance doesn't pay or if payment is remitted to me. I further agree to pay any court costs and/or legal fees incurred should my account necessitate collection procedures.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____