Concord Dental Care P.C.

Name: _____ Date of Birth: _____

Cell Phone: _____ Home Phone: _____

Email: _____

How would you want to receive your appointment reminders? (Check all that apply.)

__ Leave a voicemail at your cell number?

__ Leave a voicemail at your home number?

__ Text to your cell number?

__ Send an e-mail?

Do we have permission to discuss your condition with any member of your family? If yes, whom?

_____	_____	_____
Name	Phone Number	Relationship
_____	_____	_____
Name	Phone Number	Relationship

For Minors Only

By my signature below I, _____ as the legal

Print Full Name of Parent or Legal Guardian

Guardian/parent of _____ hereby grant Concord Dental

Print Full Name of Minor Patient

Care P.C. and it's medical personal permission to treat said minor in my absence. _____

Parent/Guardian Initials

Financial Policy and 48 Hour Cancellation/ No Show Fee Policy

Any co-payment related to an insurance-covered service is expected at the time of your visit. Most cosmetic consultations and cosmetic services are not billable to insurance, and payment is expected at your time of visit. We accept cash, check, Visa, MasterCard, Discover, and American Express for your convenience. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Concord Dental Care P.C. reserves the right to charge a fee of $50.00 for all missed appointments and appointments that are not cancelled within a 48-hour advance notice. No show and 48-hour cancellation fees will be billed to the patient. The fee is not covered by insurance and must be paid prior to the next appointment. Multiple no shows and cancelled appointments with less than a 48-hour notice in any 12-month period may result in termination from the practice.

By initialing, you acknowledge that you have received this notice and understand these policies.

_____

Patient's Initials

_____ _____

Signature of Patient or Legal Guardian Date