

Patient Name: _____ Date: _____

Responsible parties:

Name and social security number if different from patients:

INSURANCE AUTHORIZATION

I hereby give Dr. James G. Rafael, DDS, PA or Dr. Steven Bryant, DMD permission to file computer generated insurance claims without policyholder's signature for dental treatment. However, in the event that my insurance company may send me a payment, regarding any dental services I may have received, I accept responsibility of that payment and agree to pay any balance that I may have.

Signature:

_____ Date _____

FINANCIAL RESPONSIBILITY

I understand and acknowledge that I am financially responsible for the services provided for the above name, regardless of insurance coverage or myself. All patient's portions are required to be paid prior to the insertion of any prosthesis (bridges, crowns, dentures, and partials.) We do accept most major credit cards, cash or checks.

Signature:

_____ Date _____

PARENTAL CONSENT

I _____ give my consent to allow Dr. James G. Rafael, DDS, PA or Dr. Steven Bryant, DMD and staff to treat my child _____. This may consist of dental x-rays, cleanings, fluoride treatments, dental fillings, root canals, and/or extractions. I also understand that for safety reasons and child cooperation that I will not be permitted back in the treatment area with my child with the exception of children 3 years of age or younger.

Signature:

_____ Date _____

***Please make note of future appointments and that we require a 24 hours or more notice for any appointment changes. Due to many problems with broken appointments and last minute cancellations we have been forced to place a charge of **\$50.00** for all appointments cancelled with less than 18 hours notice. It is not fair to other patients to raise all fees to make up for these occurrences. When two or more family members are coming together we need to have advance notice is **ANYONE** is not coming.

There are always patients in pain or otherwise wanting an appointment that could have used the time. Broken late afternoon appointments will be rescheduled for earlier in the day. Please mark your calendars and make sure we have all your phone numbers so we can call you to remind you of your appointments. However, do not always rely on this courtesy, because it does not always work.

Signature:

_____ Date _____

***Please tell us how did you hear about our Dental Practice _____.

Dr. James G. Rafael, DDS, PA