



First Smiles

PEDIATRIC DENTISTRY

Print Patients Name: _____

Appointment Guidelines for All Patients

If you cannot keep your dental appointment, please call 24 hours in advance of your appointment to change or cancel your appointment or there will be a \$50.00 charge. Our time is important and by giving us a notice, it allows us to schedule an appointment for another patient at that time.

X _____ Date _____

(Patient or Guardian Signature) _____

Insurance Acknowledgement:

I understand that Dr. Marina Milgrom will process my insurance. If my insurance does not pay or leave a percentage due for any reason, then I become fully responsible for any unpaid co-payment or denial as said by my insurance.

X _____ Date _____

(Patient or Guardian Signature) _____

Privacy Policy Notice of Acknowledgement:

I have been advised that the privacy policies of the office are posted for my review and that I may have a copy of them if desired.

X _____ Date _____

(Patient or Guardian Signature) _____

I hereby authorize the dentist and other healthcare professionals to provide such dental care and to administer such treatment, as deemed necessary or advisable to me or the named patient each time I or the named patient present to Dr. Marina Milgrom. To the extent possible, I have been informed of risks and complications that may occur and alternatives that may be available.

Patient/ Relative or Guardian Signature: _____ Date: _____

Patient/ Relative or Guardian Print Name: _____

Relationship (If signed by person other than patient): _____

Witness Print Name: _____

Witness Signature: _____ Date: _____

Financial Policy

In our continued commitment to provide the highest quality of dental care available to all of our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment.

- Visa, MasterCard, Discover

We are committed to support you in understanding your dental health, so that you will always be able to make the best choices. We will always present you with the best dental solution possible to treat your personal situation.

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in the office; this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that all services are due to be paid in full within 90 days of date of service, regardless of whether or not my insurance benefits have been received.

We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience.

Signature (responsible party): _____ Date: _____