AURENTZ
FAMILY DENTAL

POLICY SHEET PATIENT INFORMATION

Last Name _____ MI _____ First Name _____

SS# _____ Date of Birth _____ Age _____

MISSED APPOINTMENT:
I understand there will be a charge of $25 for missed or re-scheduled appointments without a 24 hour notice. I also acknowledge and agree that any fees incurred due to missed appointments must be paid before any further treatments/cleanings.

PAYMENT POLICY:
I understand that payment is due at the time services are rendered. Any co-payments/deductibles must be paid the day of the appointment. I also acknowledge and agree that payment in full is required if my insurance cannot be verified prior to being seen.

FLOURIDE TREATMENTS:
I have been advised that my child will receive a fluoride treatment at every cleaning appointment unless otherwise requested differently by me as the parent/guardian. I also understand that if I chose not to have fluoride on my child that it is my responsibility as the parent to let the hygienist know before cleaning begins! I also acknowledge and agree it is my responsibility to know your insurance coverage and if fluoride or other treatments given in this office are a covered benefit under my insurance plan for each visit.

NITROUS (N20):
I understand that for the safety of our patients, if he/she has eaten or drank1 hour before appointment, we will have to re-schedule the appointment for another day.

X-RAYS:
I understand that if I am coming in from another office, it is my responsibility to inform Aurentz Family Dental staff of any x-rays that were taken at other dental offices. I understand that it is my responsibility to know my insurance coverage and if x-rays are a covered benefit under my insurance at time of visit(s). I understand that any x-rays taken are the property of Aurentz Family Dental, Dr. Keisha Aurentz, and originals must be kept in his office for 10 years. I understand and agree that should I leave Aurentz Family Dental and need copies of my x-rays that there will be a $25 non-refundable duplication fee and that the x-rays will only be released at my request to another dental office. I also understand that the release could take up to 3 weeks to be sent to the new provider and that the patient's account balance has to be zero in order for x-rays to be released.

INSURANCE:
I understand that it is a courtesy and not a requirement of Aurentz Family Dental to file with my primary insurance on my behalf. I acknowledge and agree that it is ultimately my responsibility as the patient to know what my plan covers and any unpaid balances not covered by insurance is my responsibility. I understand that Aurentz Family Dental will only file my primary insurance and it is my responsibility to file any secondary insurances on my own.

PARENT/GUARDIAN REPONSIBILITY (if applicable):
I understand that I as the parent am responsible for my child while under the care of Aurentz Family Dental, Dr. Keisha Aurentz. I understand that should I allow someone other than myself to bring my child to his/her appointment that any documents signed by that person or verbal acknowledgements given by that person is ultimately my responsibility and will fall back upon me.

MEDICAL RELEASE
I give permission to my Physician or Health Provider to provide health care information regarding my child(ren)(listed above) to the dentists and staff at Aurentz Family Dental

FOR CHILDREN 18 AND OVER (IF APPLICABLE)
I hereby authorize my child(ren) (ages 18 and above) to receive dental treatment (e.g. dental checkup, emergency visits, x-rays, cleaning, fluoride and/or treatment) without an authorized person accompanying him/her.

_____ _____
Signature of Patient, Parent, Guardian or Legal Representative **Date**

_____ _____
Please Print Name of Patient, Parent, Guardian or Legal Representative **Relationship to Patient**

_____ ***I, the responsible party, understand payment is due in full at time of treatment unless prior***
Initial
arrangements have been approved by the office manager.