

Stefanie Shore, DDS
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Carmichael, CA 95608
(916) 966-4341

PATIENT'S NAME: _____

FOR ALL PATIENTS:

1. I acknowledge that I have been offered a copy of the Dental Materials Fact Sheet and the office's Notice of Privacy Practice.

Signature: _____ Date: _____

2. I understand that I may be charged a 1.5% per month or 18% per year finance charge if my balance goes beyond 90 days.

Signature: _____ Date: _____

3. I understand that I may be charged \$25.00 per half hour of scheduled time if I miss an appointment or cancel without 2 business days notice. Also, I understand insurance will not cover the cost of failed appointments.

Signature: _____ Date: _____

4. I understand that photographs may be taken as a record of my care, and may be used for educational purposes in lectures, demonstrations to other patients, and marketing efforts to include websites, publications and professional publications.

Signature: _____ Date: _____

FOR PARENTS OR GUARDIANS OF PATIENTS UNDER AGE 18:

1. I authorize Dr. Stefanie Shore to perform any necessary treatment on my child.

Signature: _____

Relationship to child: _____ Date: _____