How did you hear about our office or who may we thank for referring you to us?

_____

Emergency Contact/Alternate number

Please list a local person to be notified when the parent or guardians are unavailable

Name _____ Relationship_____

Phone number _____

Our office uses text messaging/e-mail for appointment confirmations

Please list an email address or cell phone number for appointment confirmations

Email address _____

Cell number _____

□ By checking this box, I agree to opt into text messages and/or e-mail communication from Two Rivers Pediatric Dentistry.

Fee for Service Agreement

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payments in full of all accounts. A service charge of 1.5% or $5.00, whichever is greater, per month will be charged on all balances of 30 days or more past due. In the event of an action to collect the balance due on this invoice, the undersigned agrees to pay attorney's fees, expenses and court costs.

Patient or Guardian's signature _____

Date _____