New Patient Agreement

We are happy to have the pleasure of meeting your child's dental needs. Please read carefully and sign the following new patient agreement

- I understand that a parent or legal guardian must accompany my child.
- I understand that my presence in the office is required while my child is being treated at the office.
- I understand that if I do not give a 24-hour notice to cancel or change an appointment, I may not be able to reschedule an appointment or may be required to pay a scheduling deposit.
- I understand that I am responsible for notifying the office of any changes in my address or telephone number.
- If I cannot be reached due to a disconnected telephone or change of address, I am responsible for contacting the office within 24 hours to confirm my appointment; otherwise my appointment is not guaranteed.
- I understand that I am responsible for notifying the office of any other insurance coverage for my child.

Parent or Guardian:___________________________________ **Date:**_______________________