BREATHE WELL SLEEP SOLUTIONS

Date _____

PATIENT INFORMATION

Patient's name (First, Middle, Last) _____

Nickname _____

Birthdate _____

Parent or Legal Guardian's Name _____

Address (Street, City, Zip) _____

Parent or Legal Guardian's Phone Number _____

BILLING INFORMATION (if different from above)

Name (First, Middle, Last) _____

Billing Address (Street, City, Zip) _____

Phone Number _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Address (Street, City, Zip) _____

Phone Number _____

APPOINTMENT POLICY

We encourage parents to relax in the reception room during the child's visit. This helps us develop a one-on-one relationship of trust and cooperation with your child and allows us to have their undivided attention.

Appointments are scheduled depending on the treatment needed and the age of your child. We will work with you to schedule an appropriate time fro you child's age and treatment need. **Small children are seen in the morning when they are their freshest. Older children will be seen in the afternoon. We will not always be able to schedule appointments after school therefore we are always glad to provide your child a school excuse.**

The length of appointments is planned exclusively for your child and allows enough time to accomplish the planned treatment. These times are scheduled with the utmost consideration for

your child and his/her needs. It is very important that we are allowed to have the appropriate amount of time to spend with your child. If you are late for an appointment, this does not allow us the time we have reserved for your child and may delay the completion of treatment. This will possibly result in the need of another appointment, the child missing school and the parent missing work.

Initials _____ **PLEASE BE AWARE THAT IF YOU FAIL TO SHOW TO AN APPOINTMENT OR CANCEL LESS THAN 24 HOURS THERE MAY BE A FEE INCURRED OF $25.00.**

We recognize the value of your time. You can expect us to be on time for you and we would appreciate the same courtesy. We understand emergencies and other unforeseen things happening and occasionally, you will need to reschedule an appointment. **We request that you give us 24 hours' notice for a cancellation of an appointment.** This allows us to reschedule your appointment and let another patient have the time originally reserved for your child.

FINANCIAL POLICY

While we are committed to giving your child the best care available, it is important for you to know what the cost will be. We will give you an estimate based on the treatment diagnosed by the Dentist. **Remember this is only an estimate.** Occasionally, during the course of treatment, other procedures may become necessary. We will strive to keep you informed if there are changes in the estimate. **At this time, we are not accepting insurance for these treatments.**

Payment is expected at the time of service. We accept cash, checks, money orders, Visa, American Express, and MasterCard.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES.

_____

Signature of Parent or Legal Guardian

_____

Date