

Dwaine E. Valentine, D.D.S., Inc.
Office Policy as of January 2021

- Our policy is to make your experience in our office an exceptional one. When we succeed, we would appreciate you telling your family and friends about our office.
- A true dental emergency is swelling, bleeding, severe pain that has kept you up at night requiring medication, or a restoration in a visible area that falls out. If you have any of these symptoms, we ask that you call us right away. We will provide you with the next available emergency appointment.
- Timeliness is required. We strive to see you on time and dismiss you on time for your visits. If you are more than 10 minutes late, you may have to reschedule your appointment.
- We understand that unavoidable circumstances occur. However, no-shows are not acceptable. Failure to show for an appointment not only compromises your health but inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot make an appointment (except in the case of an emergency) you are expected to call within 48 hours of your appointment to reschedule. If you fail to show for your appointment, we will charge your account a \$70.00 fee. These costs are not covered by insurance.
- We run a Zero Balance office. We expect payment in full prior to or at the time of service. Financial options are available. Please ask Jeanie if you have any questions.

Patient Signature

Date

Patient Printed Name

How would you like for us to communicate with you?

Our office sends appointment reminders, information about treatment and insurance, and other communications. Please tell us how you would like for us to communicate with you.

Check **all** that apply (**Please print clearly**):

- U.S. Mail at the following address:
- Email at the following address:

FOR PHONE AND TEXT COMMUNICATIONS:

Cell Phone _____ May we text and call this number? Yes _____ No _____

Home Phone _____ May we call this number? Yes _____ No _____

- By checking this circle, I consent to the following: Our dental practice or its service provider may contact me to provide health care information such as account or insurance, using artificial or prerecorded choice or telephone equipment that may be capable of automatic dialing.

Signature _____ Date _____

Please call our office if any of your contact information changes.