

REGENCY COURT DENTISTRY

Dental Insurance Information

Insurance Company: _____ Phone #: _____ Group #: _____

Subscribers Name: _____ DOB: _____ SSN: _____

Insurance Employer: _____ Member ID#: _____

Referral Information

Internet Newspaper Yellow Pages Post Card Sign/Saw office

Family _____ Magazine _____

Dentist. /Physician _____ Friend _____

Event (please specify) _____

Other (please specify) _____

Broken/Missed Appointments

Your scheduled appointment is reserved specifically for you. If a cancellation is unavoidable, please call the office at least 24 hours in advance so that we may give your appointment time to another patient. If you do not cancel your appointment with more than 24 hours' notice, we will consider this to be a broken/missed appointment. A broken appointment is subject to a \$50 broken appointment fee. If 2 broken appointments occur, our office reserves the right not to schedule any subsequent appointments for your child.

Occasionally, we understand illnesses, and life's emergencies make it necessary to cancel an appointment with less than 24 hours of notice. Please contact our office immediately and we will do our best to accommodate your situation.

SATURDAY APPOINTMENTS WILL REQUIRE A DEPOSIT.

Patient Signature: _____

Date: _____