Marilyn Amaral, D.D.S. P.A.
General and Cosmetic Dentistry
FOREVERS ILE

Date: _____

PATIENT RESPONSIBILITY

I _____ acknowledge that if my Insurance does not cover my treatment, I will be responsible for the payment to DR. Marilyn Amaral.

- I also will be responsible for all my co-payment and deductibles.
- If I do not have dental insurance, I will pay for my dental work in full on my Date of Service.

CANCELLATION:

If I'm going to cancel my appointment, I will do so with at least 48 hours of anticipation. If I do not cancel my appointment within 48 hours' notice, or do not show to my dental appointment, I will be charged a fee of $50.00 per hour of treatment time after the third missed appointment with less than a 48hour notice.

_____ _____
Patient Signature **Parent Guardian**

X-Ray Patient Consent Form

Patient Consent to X-Ray

I authorize the performance of diagnostic x-ray examination of myself which Dr. Amaral considers necessary in the course of my examination and treatment.

_____ _____
Patient Signature ***Parent Guardian***

If Patient is a Minor

I am the parent or legal guardian representative of_____ who is a minor, _____years of age. I authorize the performance of diagnostic x-ray of this minor which Dr. Amaral considers necessary.

_____ _____
Patient Signature ***Parent Guardian***

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am not pregnant, and Dr. Amaral has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to and unborn child.

_____ _____
Patient Signature ***Parent Guardian***