Patient Name: _____ Date of Birth: _____

Sterling Dental is committed to helping you manage and maintain your dental care needs. When you schedule an appointment with one of our doctors or hygienists, that time is reserved exclusively for you. We do understand that, on occasion unforeseen circumstances arise and the need to cancel your scheduled appointment may be necessary.

If you know that you will be unable to keep your appointment, we ask you to show consideration by calling by calling our office 24 hours in advance. Providing our office with adequate notice will allow us to offer that appointment time to another patient who needs to see our doctors or hygienists.

NO-SHOW fee is $50.00. This fee must be paid before your next appointment.

CO-PAYS – All co-payments must be paid at the time of your visit.

RETURNED CHECK FEE – Our office charges $35.00 for each NSF received

Signature: _____ Date: _____

Agreement to Receive Electronic Communication

I agree that Sterling Dental may communicate with me electronically, at the email address and/or cell phone number that I have provided.

I am aware that there is some level of risk that third parties might be able to read unencrypted messages.

I am responsible for providing Sterling Dental with any updates to my email address or telephone number.

I can withdraw my consent to electronic communications by calling: Sterling Dental (586) 939-7788.

Signature: _____ Date: _____

Acknowledgement of Receipt of notice of Privacy Practices

You may refuse to sign this acknowledgement

I have received a copy of this office's Notice of Privacy Practices

Print Name: _____

Signature: _____

Date: _____