MYRON FISHBEIN D.M.D.,P.A.

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PATIENT'S NAME_____ DATE_____

I HAVE READ , UNDERSTAND AND AGREE TO THE STATEMENTS BELOW:

[A] TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEEDING ANSWERS PERTAINING TO MY/ CHILD'S / MINOR'S MEDICAL HISTORY ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGES IN THE MEDICAL HISTORY, OR MY MEDICINES/ MEDICATIONS CHANGE, I WILL INFORM DR. MYRON FISHBEIN AT THE NEXT APPOINTMENT WITHOUT FAIL IN WRITTEN FORM SO THAT IT CAN BE INCORPORATED INTO MY PREVIOUS MEDICAL HISTORY.

[B] I UNDERSTAND THAT ALL DENTAL SERVICES OR PROCEDURES MAY NOT BE FULLY COVERED BY THE INSURANCE OR UNION EMPLOYMENT DENTAL PLANS. I/WE AGREE TO PAY FOR ALL SERVICES OR PROCEDURES NOT COVERED BY INSURANCE OR DENTAL PLANS. I AUTHORIZE TREATMENT AND AGREE TO PAY ALL FEES AND CHARGES FOR TREATMENT ON THIS PATIENT. I GIVE DR. MYRON FISHBEIN THE AUTHORITY TO SIGN THE INSURED'S NAME TO A DENTAL INSURANCE CLAIM FORM SHOULD I FORGET TO GIVE HIM A PROPERLY FILLED OUT FORM.

[C] I AUTHORIZE TREATMENT AND AGREE TO PAY IN FULL ALL FEES AND CHARGES FOR TREATMENT ON THIS PATIENT AT THE TIME OF SERVICE. I UNDERSTAND THAT IF I SHOULD BE DELINQUENT WITH PAYMENT OF ANY PORTION OF MY AND OR MY FAMILY'S BALANCES BEYOND 30 DAYS THERE WILL BE AN INTEREST CHARGE PLACED ON THE ACCOUNTS IN THE AMOUNT OF 1 1/2 % PER MONTH. IF THE BALANCE IS NOT PAID AND THUS LEGAL ACTION IS TAKEN, I SHALL PAY ALL COSTS OF COLLECTION. I UNDERSTAND THAT IF THE BANK RETURNS MY CHECK TO DR. FISHBEIN'S OFFICE FOR INSUFFICIENT FUNDS, THAT I SHALL BE RESPONSIBLE FOR A $50.00 RETURN FEE.

[D] I UNDERSTAND THAT FROM TIME TO TIME THERE IS A POSSIBILITY THAT ANOTHER DENTIST WILL RENDER TREATMENT TO THE PATIENT IN DR. MYRON FISHBEIN'S OFFICE. THIS DENTIST IS INDEPENDENT OF DR. FISHBEIN AND COMPLETELY CONTROLS THE TREATMENT RENDERED TO THE PATIENT.

[E] *FOR FEMALES* - I UNDERSTAND THAT IF I TAKE ANTIBIOTICS OR OTHER MEDICATIONS, I.E., PENICILLIN, ERYTHROMYCIN, TRANQUILIZERS, ETC., DURING THE TIME THAT I AM TAKING BIRTH CONTROL PILLS, I MUST USE AN ALTERNATE METHOD OF CONTRACEPTION DURING THAT PERIOD AND FOR THE TIME AFTER TERMINATION OF THE MEDICATION, UNTIL MY NEXT MENSTRUAL CYCLE.

X_____
PATIENT, PARENT OR GUARDIAN'S SIGNATURE DATE

RELATIONSHIP TO PATIENT ____