PHOTOGRAPH FORM

I, ________________________________, understand Smith Dental Care will take my full face photograph. I understand that this photograph will only be seen by employees of Smith Dental Care and me, unless otherwise authorized.

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Signature of Patient Date

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Signature of Staff

INSURANCE INFORMATION

Smith Dental Care is **OUT OF NETWORK** with your dental insurance provider. However, we can file on most insurance. You are responsible for any charges not covered by your insurance company. If your insurance company requires a deductible for your dental visit, you will be responsible for paying the deductible on that visit.

ACCEPTED AND AGREED TO BY:

______________________________ ____________________

Signature of Patient Date