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. **Initial** _____

Video Policy

We ask that you refrain from cellular use while in the clinical areas. For the privacy of our patients, staff, and doctors, we do not allow videos to be taken while we are treating our patients. **Initial** _____

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. **Initial** ____

ACCEPTED AND AGREED TO BY:

_____ _____

Signature of Patient Date

Updated: 9-1-2021