Name: ____ Date: ____________________

Blood Thinner

I understand that certain procedures require me to be off my blood thinner/aspirin. I understand it is my responsibility to contact my prescribing physician when discontinuing the use of my blood thinner or aspirin.

Signature:_______________________________________

Medicare (Only complete this section if you have Medicare)

I understand Medicare does not cover any services rendered in Dr. Munz office. Therefore, I agree to a private pay agreement between myself and Dr. Munz.

Signature: ____

Share Information

I give permission to share my dental records/information to the following:

Name: _________________________________Relationship:__________Phone#_________________

Name:_________________________________ Relationship:__________Phone#_________________

Missed Appointment Policy

It is the patient and/or guardian's responsibility to remember the allotted appointment. As a courtesy we will notify by a phone call. If you do not call our office 24 hours before the allotted appointment time to cancel or reschedule, there will be a $75 missed appointment charge.

Signature:____