DeJesus Dental Group
COSMETIC, FAMILY & IMPLANT DENTISTRY

Your appointment time has been especially reserved for you. Should you be unable to keep your appointment, a minimum of 24 hours notice is appreciated. A fee is charged for patients who miss or cancel their appointment without 24 hour notice.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)

Photo Release

I understand that photographs, x-rays, and other records may be made during the course of my examination, treatment, and follow-up care. I give permission for such items to be used for purposes of research, education, or publication in professional journals or advertising.

Patient Signature:_____Date:_____

Witness:_____

24 Hour Cancelation and Photo Release