Smith & Rockefeller
FAMILY AND COSMETIC DENTISTRY

Christopher H. Smith, DMD
Van P. Rockefeller, DMD

GUARANTOR CONSENT FORM

I, the undersigned, agree to be the responsible party (Guarantor) and promise to pay for any services rendered by any provider at Smith & Rockefeller, PC, for the patient(s) listed below:

Patient ______________________________ Date of Birth ______________

Patient ______________________________ Date of Birth ______________

Patient ______________________________ Date of Birth ______________

Patient ______________________________ Date of Birth ______________

I understand by signing this form that all responsibility for payment for dental services provided in this office for myself or the patient(s) listed is due and payable at the time services are rendered. In the event payments are not received by the agreed upon dates, I understand that finance charges may be added to my account. If I default on payment of my account I realize I may be charged a reasonable collection fee.

I understand the responsibility is mine to advise your office of any changes in the information contained on this form.

Responsible Party (Guarantor) Information:

Parent or Responsible Party ______________________________ Date ______________

Relationship to Patient(s) ______________ Date of Birth ______________ Social Security # ______________

Address ____

City ______________________________ State ________ Zip ______________

Home Telephone ______________________ Work Telephone ______________________

Email Address ______________________ Cell ______________________

In the event I no longer wish to be responsible for the accounts listed above, I understand I must notify the dental office of Smith & Rockefeller in writing and all account balances must be paid in full before I am released as the Guarantor.

Signature ______________________________ Date ______________
Parent, Responsible Party (Guarantor), Legal Guardian