DIXON PEDIATRIC DENTAL GROUP

Eric H. Dixon, DDS
Stephanie L. Dixon, DDS
Howard R. Dixon, DDS, MS
Kimberly D. Sauer, DDS
Rachel Swimmer, DDS
Breanne Reid, DDS

CONSENT TO TREAT MINOR

Date _____

As parent(s)/guardian(s) of_____ I/we authorize Dixon Dental Group to examine- and treat my child as necessary. I understand that by signing this form I am excepting all responsibility or full payment of services rendered. If I have insurance coverage I understand that information such as deductible, waiting periods, co-insurance, etc., given to the office by my insurance company is only an estimate and never a guarantee of coverage or payment. I am aware that the office requires 48 business hours notice for any cancellation of scheduled appointment/s and if notice is not given there may be a charge of $50 per appointment canceled. I further understand that all payments are due and payable on the day and services are rendered.

Patient Home Address _____

City/State _____ Zip _____ Phone _____

Email Address _____

Dr. Mr. Mrs. Ms.

Name _____ **Relationship** _____

Address (if different than above) _____

Phone (if different than above) _____ SS # _____ DOB _____

Employer Name _____ Occupation _____

Work Phone _____ Cell Phone __ _____

E-mail Address _____

Signature _____

Whom may we thank for referring you?_____

Friend or Relative not living at same address to contact in the event of an emergency:

Name _____ **Phone** _____

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5627 Oberlin Drive, #100, San Diego, CA 92121 • (858) 452-7272 • Fax (858) 452-0657