DIXON PEDIATRIC DENTAL GROUP

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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** _____