SAN DIEGO PEDIATRIC DENTAL GROUP
Howard R. Dixon, DDS, MS & Associates
Diplomate, American Board of Pediatric Dentistry

CONSENT TO TREAT MINOR

Date: ______________________________

As parent(s)/guardian(s) of ________________________________ I/We authorize Dr's Howard Dixon and associates to examine and treat my child as necessary. I understand that by signing this form I am accepting all responsibility for full payment of services rendered regardless of insurance coverage. I further understand that all payments are due and payable on the day services are rendered.

Patient Home Address ____

City/State ____ Zip________________ Phone ( ) ____________________

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: ____

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 (** **)** ____________________________________