Jessica Wagner Sabo DDS, Inc

Personal Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Alternate Phone: _____

Email _____

SSN: _____

Birth Date: _____ Gender: M F Age: _____

Parent/Guardian Name: _____

Emergency Contact: _____

Physician's Name: _____ Date of Last Visit: _____

List any Medications: _____

Was a Vitamin K shot given at birth(to the baby)? □ Yes □ No □ I Don't Know

Allergies: □ None Known □ Local Anesthetics □ Latex □ Penicillin □ Other _____

The information on this form is accurate and complete to the best of my knowledge and is only for use in my treatment and billing. I will not hold my dentist or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Date Signature of Parent/Guardian

Consent for Treatment

I, being the parent or guardian of _____
Name of minor /child

Do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date Signature of Insured/Parent/ Guardian

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges.

_____ _____
Date Signature of Insured/Parent/Guardian