PAGE 1	
Date Y M D	
Mr. Mrs. Mrs. Surname Given Name	Chart — — Middle Initial
Sex: MF	Date of Birth: Y M D
Address	•
City Occupation	Postal Code
Phone Home	Work
	mail
Dental Insurance YesNo	
Parent or Guardian (if under 18) or Next of Kin	
Person responsible for payment: Self or	(specify) Phone #
Insurance Co	Personal Physician
Address	Address
Phone	Phone
CONSEN	T TO TREATMENT
I have had the treatment procedure(s) and the estimate	ed fee for the procedure(s) contained in the treatment plan dated
explained to me, I u	nderstand their significance and I consent to the treatment procedure(s).
· .	
Signature of Parent/Guardian	
Doctor	
Date	