Phone: 619-435-6655

Dr. Howard R. Dixon's
CORONADO PEDIATRIC DENTISTRY

Fax: 619-435-6644

# Consent To Treat Minor

Howard R. Dixon DDS, MS & Associates • 875 Orange Ave. Ste 210 Coronado, CA 92118

Welcome to our office. We appreciate the confidence you place with us to provide your child(ren) dental needs. To assist us in serving you, please complete the following information.

**CHILD'S INFORMATION**

Patient Name: _____ Date of Birth: _____ Sex: _____ Age: _____
Home Address: _____ City: _____ Zip: _____
Billing Address (If Different): _____City: _____Zip: _____
Home Phone: (____) _____ Cell Phone: (____) _____ Best Time to Call: _____
**Who can we thank for referring you/ how did you hear about our office?** _____

**GUARDIAN INFORMATION**

Name: _____ DOB: _____ SS# _____ Relationship_____
Home Address: _____ City: _____ Zip: _____
Home Phone: (____) _____ Cell Phone: (____) _____ Best Time to Call: _____
Email: _____

Name: _____ DOB: _____ SS# _____ Relationship_____
Home Address: _____ City: _____ Zip: _____
Home Phone: (____) _____ Cell Phone: (____) _____ Best Time to Call: _____
Email: _____

**INSURANCE INFORMATION**

**PRIMARY INSURANCE:**
Name of Dental Insurance: _____
Phone Number: _____
Policy Holder Name: _____
Date of Birth: _____ SS# _____
Member ID/ Subscriber ID: _____
Employer/ Service Branch: _____
(If active member) Ranking: _____

**SECONDARY INSURANCE:**
Name of Dental Insurance: _____
Phone Number: _____
Policy Holder Name: _____
Date of Birth: _____ SS# _____
Member ID/ Subscriber ID:_____
Employer/ Service Branch:_____
(If active member) Ranking: _____

**CONSENT TO TREAT A MINOR**

As parent(s)/guardian(s) of _____I/We authorize Dr. 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 service rendered regardless of insurance coverage. I further understand that all payments are due and payable on the day services are rendered.

Signature of Responsible Party: _____ Date_____

**CANCELLATION/ MISSED APPPOINTMENT NOTICE:**

WE ASK FOR 48 BUSINESS HOUR NOTICE OF ANY CANCELLATION OF A SCHEDULED APPOINTMENT. **IF NOTIFICATION IS NOT GIVEN, THERE IS A $50.00 FEE PER ROUTINE APPT AND $100.00 FEE PER TREATMENT APPT**. IF APPOINTMENT IS FOR ORAL SEDATION/ GENERAL ANESTHESIA, WE ASK FOR 72 BUSINESS HOURS NOTICE TO AVOID LOSS OF YOUR DEPOSIT.

Signature of Responsible Party: _____ Date_____