CORONADO PEDIATRIC DENTISTRY
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 ( )** _____