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PLEASE LIST ALL DRUGS AND/OR OTHER THINGS THAT CAUSE YOUR CHILD ALLERGIC REACTIONS \_

## PRIMARY DENTAL INSURANCE

SIGNATURE OF RESPONSIBLE PARTY

DORESS CITY STATE ZIP  DORESS CITY STATE ZIP  APLOYER  BUSINESS ADDRESS  OCCUPATION  SURANCE COMPANY  SURANCE COMPANY ADDRESS  BESCRIBER I.D. #  PERSON RESPONSIBLE FOR ACCOUNT  RELATIONSHIP TO PATIENT  BIRTHDATE  SOCIAL SECURITY #  HOME PHONE  CITY STATE ZIP  ADDRESS  CITY STATE ZIP  BUSINESS PHONE  BUSINESS ADDRESS  OCCUPATION  INSURANCE COMPANY  INSURANCE COMPANY  INSURANCE COMPANY ADDRESS  SUBSCRIBER I.D. #  GROUP #   ASSIGNMENT AND RELEASE  I AFFIRM THAT THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. IT WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANCES IN MY CHILD'S MEDICAL STATUS. I AUTHORIZED THE DENTAL STAFF TO PERFORM THE NECESSARY DENTAL SERVICES MY CHILD MAY NEED. MY METHOD OF PAYMENT WILL BE  SIGNATURE OF PARENT OR GUARDIAN  DATE	ELATIONSHIP TO PATIENT	BIRTHDATE
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DATE

DENTAL SPECIALISTS, LLC