Patient Therapy Authorization Form

DENTAL OFFICE *(please print & circle where appropriate)*

Name of Doctor ______________________

Prescribed Procedure ($85.00 each):
Upper Impression / Lower Impression / Occlusal Measurement / Try-in / Insert

____

____

Authorized Signature ______________ Name ______________ Date ____ mm ____ dd ____ yy

Please bill directly to: Our Clinic / Patient

SIGN & FAX to 780.429.0809

Services directly billed to patients are not eligible to be claimed as tax deduction and cannot be submitted to insurance company for reimbursement.

PATIENT INFORMATION *(please print & circle where appropriate)*

Mr / Mrs / Ms ______________ Last ______________ First ______________ Middle

Daytime Tel: ______________ Cell: ______________

Appointment Date: ____ mm ____ dd ____ yy Time: ______________ AM / PM

By Appointment ONLY.

Any allergies/medical conditions (latex / hepatitis / HIV etc.)? ______________

LAB ONLY *(please print)*

Technical assessment and/or recommendations:

____

____

Registered Technician: ______________________

In-lab patient charges: $ ______________ Estimated by: ______________

All in-lab patient charges/procedures are subject to change.

PATIENT

I hereby acknowledge receipt of my ______________________ in good order.

Patient Signature ______________________ Date ____ mm ____ dd ____ yy

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