



Patient Therapy Authorization Form

DENTAL OFFICE <i>(please print & circle where appropriate)</i>		
Name of Doctor _____		
<i>Prescribed Procedure (\$89.00 each):</i> Upper Impression / Lower Impression / Occlusal Measurement / Try-in / Insert		
Authorized Signature _____	Name _____	Date _____ <small>mm dd yy</small>
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 <i>(please print & circle where appropriate)</i>		
Mr / Mrs / Ms _____	_____	_____
<small>Last</small>	<small>First</small>	<small>Middle</small>
Daytime Tel: _____	Cell: _____	
Appointment Date: _____	Time: _____	<small>AM / PM</small>
By Appointment ONLY.		
Any allergies/medical conditions (latex / hepatitis / HIV etc.)? _____		

LAB ONLY <i>(please print)</i>
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 _____ <small>mm dd yy</small>

030117