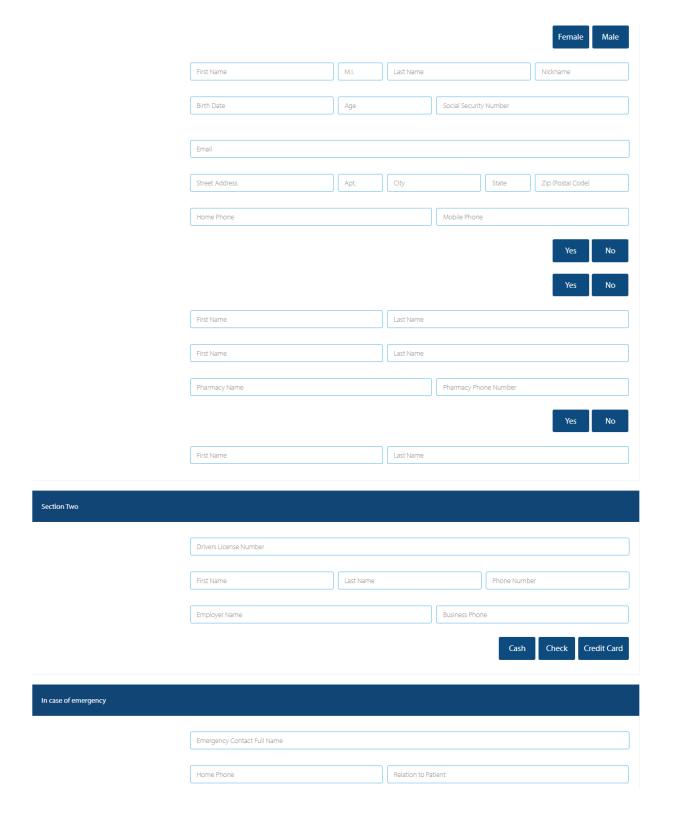
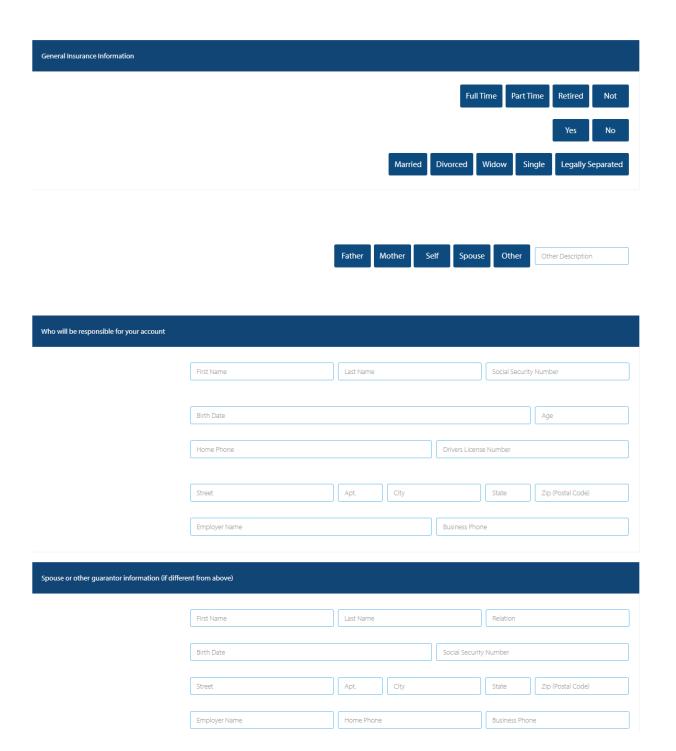


	Date of 1st vaccination	ite of 1st vaccination	
	Date of 2nd vaccination		
	Date of vaccination		
Click to Sign		Date:	
ID-19 Pandemic Dental Treatment Notice and Acknowledgement of Risk Form			
Click to Sign		Date:	

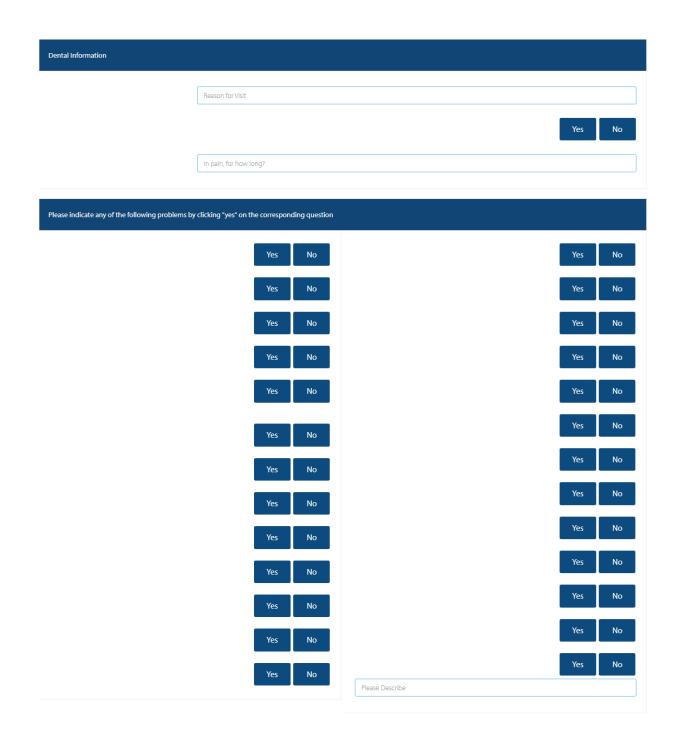
Patient Information

Mr. Mrs. Ms. Dr.

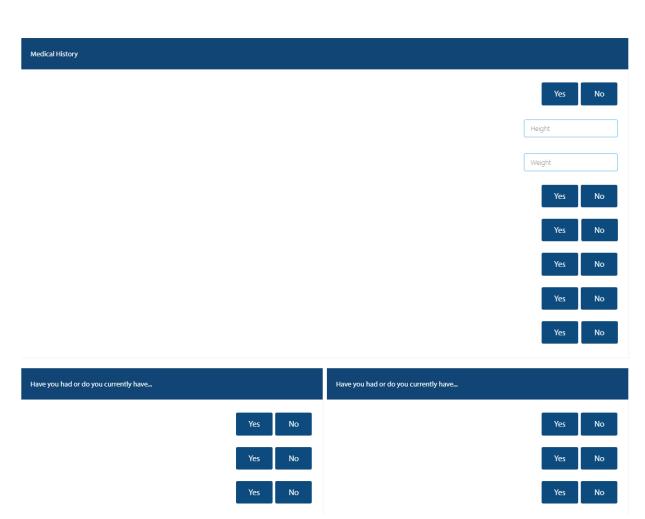




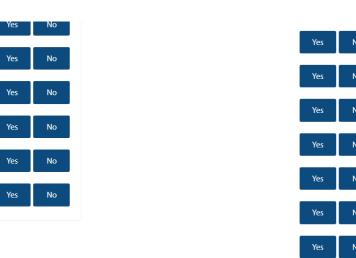
Primary Insurance Information				Secondary Insurance Information	no		
			Dental Medical				Dental Medical
	Employer / Business Na	ame			Employer / Business N	lame	
	Street Address				Street Address		
	City	State	Zip (Postal Code)		City	State	Zip (Postal Code)
	Business Phone				Business Phone		
	Plan Name				Plan Name		
	Insurance Company Na	ame			Insurance Company N	lame	
	Insurance Policy I.D. Nu	ımber			Insurance Policy I.D. N	umber	
	Insurance Company Ac	State	Zip (Postal Code)		Insurance Company A	State	Zip (Postal Code)
	Insurance Company Ph	none			Insurance Company P	hone	
							Sava Mara
	Group Number		iroup Name		Group Number	l	Group Name
	First Name		ast Name		First Name		Last Name
	Relation to Patient	] [_B	lirth Date		Relation to Patient		Birth Date
			Male Female				Male Female
	Street Address				Street Address		
	City	State	Zip (Postal Code)		City	State	Zip (Postal Code)
	Insured Party Phone	S	SN		Insured Party Phone		SSN







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Yes No

Are you now taking:

Yes No



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Click to Sign	Date:
<u> </u>	
Click to Sign	_
	Date: