JASON J. AUGUSTINE
D.D.S., M.S., P.C.
4025 W Bell Rd #4, Phx AZ 85053
Phone: 602-978-6910

Consent to Exam

- I,_____ hereby authorize Dr. Augustine and his staff to take radiographs, study models or order appropriate lab and diagnostic tests that would be necessary to make a thorough diagnosis of the patient's dental or periodontal needs.

  PATIENT / GUARDIAN: _____ Date_____

Account Information of Responsible Party, (patient or guardian)

NAME (if different than above): _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

I understand that I am responsible for all charges not covered by my insurance plan.

PATIENT / GUARDIAN: _____Date_____

Dental Insurance Information, (please present your insurance card)

Primary

Name of insured (if other than patient) _____-

Subscriber ID# _____ _____ _____ **subscriber birthdate (mm/dd/yy)** ___ ___ ___

Relationship to patient_____

INSURANCE COMPANY: _____

EMPLOYER: _____, **GROUP #:** _____

Claim office address (if not on card)_____

Insurance phone_____

Secondary

Name of insured _____

Subscriber ID#_____ _____ _____ **Subscriber birthdate (mm/dd/yy)**____ ___ ____

Relationship to patient_____

INSURANCE COMPANY: _____

EMPLOYER: _____, **GROUP #:** _____

Claim office address_____

Insurance phone _____