JASON J. AUGUSTINE, DDS, MS, PC & ASSOCIATES

JASON J. AUGUSTINE, DDS, MS, PC DIRK M. DONOVAN, DMD, MSD
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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)___ ___ ___

Relatonship 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)____ ___ ____

INSURANCE COMPANY: ____

EMPLOYER: _____________________________________, GROUP #: __________________

Claim office address____

Insurance phone _________________________________