

Dr. Peter D. Balega, DDS
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770-834-6663

EMERGENCY INFORMATION

Please complete the information below so that we may contact the appropriate person, outside your household, in the event of an emergency.

Thank-you.

Name _____ Relationship _____

Address _____

Home _____ Work _____

Phone # _____ Phone # _____

ALTERNATIVE CONTACT:

Name _____ Relationship _____

Address _____

Home _____ Work _____

Phone # _____ Phone # _____

CHARGE FOR TRANSFERRING X-RAYS

There will be a nominal fee of \$10.00 for duplication of x-rays if x-rays are to be duplicated in the event of transferring.

Signature

CANCELLATION NOTICE

I realize I will be charged \$20.00 on my scheduled office visit if I do not give at least 24 hours notice of cancellation; unless it is due to an unforeseeable emergency.

This policy has been reviewed with me.

Patient's
Signature: _____ Date: _____

Witness
Signature: _____ Date: _____