Dr. Peter Balega
Family Dentistry

**EMERGENCY INFORMATION**

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

Name: _____ Relationship: _____

Address: _____

Cell #: _____ Work #: _____

**ALTERNATIVE CONTACT**

Name: _____ Relationship: _____

Address: _____

Cell #: _____ Work #: _____

- **I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.**

_____

_____

**CANCELLATION NOTICE**

I realize that I will be charged the amount of $50.00 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 by me.

Patient/Guardian's Signature _____

Date: _____