SARANAC LAKE VOLUNTARY HEALTH ASSOCIATION, INC.
81 MAIN STREET, SUITE 3
SARANAC LAKE, NY 12983
518-891-0910

Request for Dental Assistance EMERGENCY

Name of Patient:______________________________Date of Birth:________________
Name of Applicant if Patient is a Minor:____
Present Address:____
Mailing Address (if different):____
Home Phone No.:_____________Work Phone No.:_____________Cell No.:__________
School District of Residence:____________________Referred by:________________

1. What is your dental problem? ____

2. Are you in pain? ____

3. Who is your dentist? ____

4. Estimated cost of emergency treatment (single visit): ____________________

5. Do you have insurance to cover the cost? ______________________________

6. I will pay $______________of the cost of the emergency care given by the dentist.

APPROVED for remaining balance of emergency care cost by dentist up to $250.00.

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Authorized Signature   Date

Notes: ____

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