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: _____ Work Phone: _____ Cell Phone: _____

School District of Residence: _____ Referred by: _____

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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.

_____
Authorized Signature Date

Notes: _____

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