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: _____

---

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.

APPROVAL VALID FOR 10 DAYS FROM DATE APPROVED.

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

_____
Authorized Signature Date

Notes: _____

_____