PLUM GROVE DENTAL ASSOCIATES

222 N. Plum Grove Rd.
Palatine, IL 60067-5233

Minor Patient's Parent Information

* Information Regarding **MOTHER** of Minor Patient:

Name: _____
LAST FIRST MIDDLE

Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Number: _____

Employer: _____

Employer's Phone Number: _____

Address of Employer: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____

Date of Birth: _____

* Information Regarding **FATHER** of Minor Patient:

Name: _____
LAST FIRST MIDDLE

Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Number: _____

Employer: _____

Employer's Phone Number: _____

Address of Employer: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____

Date of Birth: _____

Disclosure statement for minors:
I hereby authorize Plum Grove Dental Associates to treat my minor son/daughter,

_____ (Minor's Name)

Signed _____