AUTHORIZATION FOR SEALANTS

Patient's Name _____

SEALANTS HAVE BEEN RECOMMENDED FOR MY CHILD. I UNDERSTAND THE BENEFIT OF THEIR USE AND THAT MY INSURANCE COMPANY MAY NOT PAY FOR THIS SERVICE. I WILL ASSUME FINANCIAL RESPONSIBILITY FOR THE FEE.

********** **SEALANTS ON PERMANENT MOLARS ARE $65.00 PER TOOTH** **********
**********SEALANTS ON PRIMARY TEETH ARE $35.00 PER TOOTH**********

_____ I WISH TO HAVE THIS RECOMMENDED SERVICE PROVIDED FOR MY CHILD.

_____ I DO NOT WISH TO HAVE THIS SERVICE PROVIDED AT THIS TIME.

_____ NUMBER OF SEALANTS #'S _____

_____ _____ _____

Parent or Legal Guardian Signature **Witness** **Date**

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