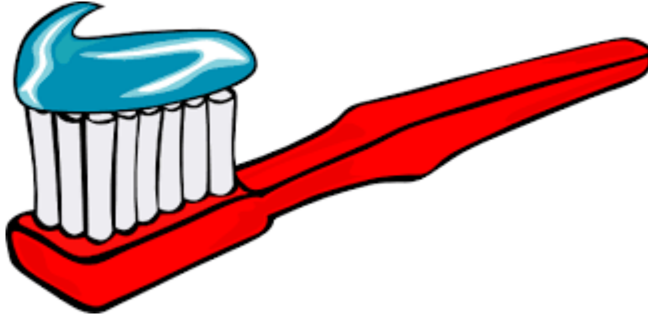

APPLICATION OF FLOURIDE WAIVER

Date:___________________________________

I understand that on this date, my child, ____ has received a fluoride treatment at the office of West Haven Pediatrics, LLC. The cost of such treatment is $35.00

In the event that my insurance company denies payment for this service, I agree to pay the outstanding amount due to West Haven Pediatrics within 45 days of such service rendered.

Parent/Guardian Signed:____

Print Name: ____