ABIDING CHOICE, INC.
DENTAL CONSULT FORM

Individual: ______________________________________

Date: ____

Allergies: _______________________________________

Name of Dentist (Print Name): _______________________

Dentist Phone Number: ____________________________

Purpose of Visit:

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Findings/Recommendations:

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Return Visit Date:

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Dentist Signature ____________________________ Date ____________________

* HCS Dental Services requires prior approval from Abiding Choice, Inc. Please call 512-430-7334 or 512-446-3115 to verify HCS funding prior to obtaining dental services. You may fax invoices to 512-446-4742

Lasting Care for your Loved Ones