Accountability Form

To be completed by the Dental Practice

Details of dentist	
Surname	
Name	
Practice Number	
Telephone Number	

Details of patient	
Surname	
Name	
Scheme & Option	
Member Number	

Details of procedures/amounts not covered by the Scheme		
Procedure code	Description	Amount

To be completed by the Main Member

I _____

(Full Names and Surname)

Scheme _____ Option _____

Member No _____

Hereby accept full responsibility for payment of the above mentioned procedures and amounts not covered by the Scheme.

_____ _____

Signature Date

By signing this form, I agree that the main member is aware of this agreement (if signed by the dependant.)*

**If the dependant is under the age of 18, a registered dependant over the age of 18 needs to sign on their behalf, if the main member is not present*

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