St Pauls Garda Medical Aid Society

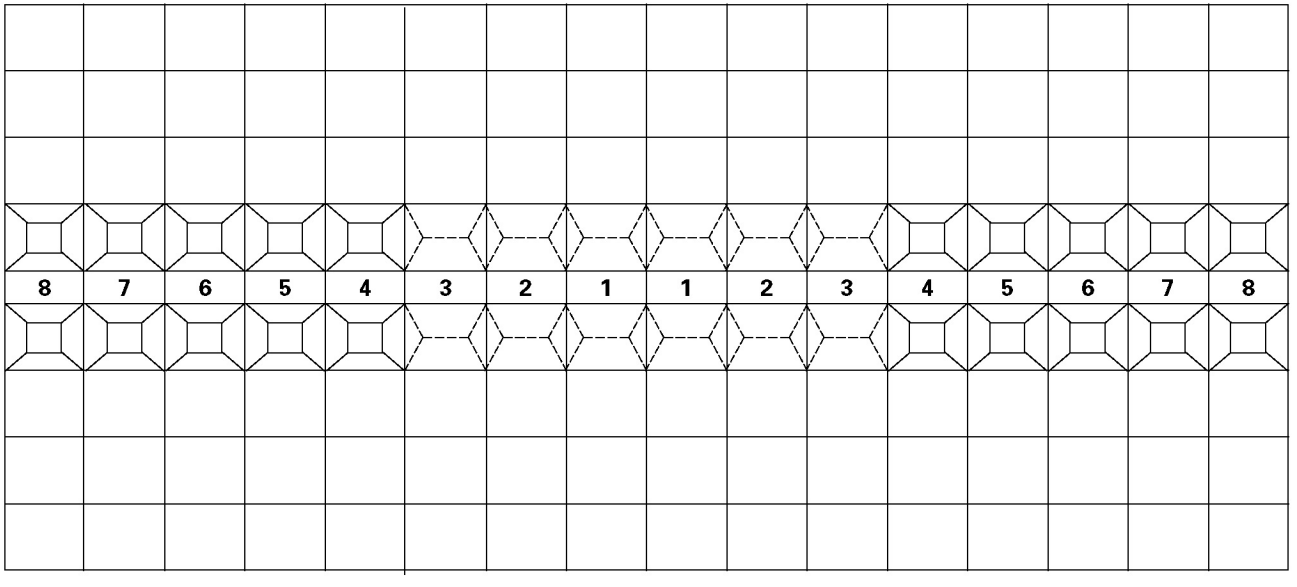
Registered Number:_____ Name of Patient: _____

TO BE COMPLETED BY THE DENTIST

DATE	*TREATMENTS*	*COST*
1		
2		
3		
4		
5		

This is not a receipt - to be accompanied by a receipt on dentist headed paper.
Ma3 form must be completed by a member

OVER



Signature of Dentist:_____