



# 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: \_\_\_\_\_