



Date: _____

I hereby authorize and request the performance of dental services for myself or for:

_____ Age: _____

_____ Age: _____

_____ Age: _____

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment.

I understand and acknowledge that I am financially responsible for the services provided for myself or for the above named, regardless of insurance coverage

Signature of responsible party