HARBORCREEK DENTAL

Responsibility and Consent Statement

Date: _____

I hereby authorize and request the performance of dental services for: _____. I also give my consent to any necessary and advisable dental procedures, radiographs, medications, or anesthetics to be administered by the attending dentist or by the staff for diagnostic purposes or treatment. This authorization is effective for the dental services provided during the date range _____to _____.

I also understand that I am financially responsible for the services provided for _____, regardless of insurance coverage.

_____
Signature of Responsible Party

_____
Printed Name of Responsible Party

_____
Relationship to Patient

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