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RESPONSIBILITY AND CONSENT STATEMENT

I, _____, hereby authorize and request the performance of dental
(Responsible Party)

service for _____.
(Patient's Name)

I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or supervised staff for diagnostic purposes or dental treatment. I understand and acknowledge that I am financially responsible for the services provided for the above named person, regardless of insurance coverage.

Signature: _____ Date: _____

Relationship to Patient: _____