Responsibility and Consent Statement

Decatur Dental

Sven Hoge, D.M.D.

501 S. Washburn St.

Decatur, TX 76234

940-627-2514

Date ___________________

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

______________________________________ 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 diagnostics purposes or dental treatment.

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

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(Signature of responsible party)

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(Relationship to other(s) named)