RESPONSIBILITY AND CONSENT STATEMENT

BURKE SEDATION DENTISTRY

8996 Burke Lake Rd., Suite 200
Burke, VA 22015
Tel: (703) 503-8996

Date _____

I, _____, hereby authorize and request the performance of
(print name)

dental services for myself and/or for:

_____ Age: _____

_____ 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 the above named, regardless of insurance coverage.

_____
(Signature of responsible party)

_____
(Relationship to other(s) named)