SCHNEIDER
DENTAL

Patient Responsibility and Consent Form

I, _____ authorize and request the performance of
Parent or Guardian's Name
dental services for my (son/daughter) _____. I
Patient's Name
understand and acknowledge that I am financially responsible for the above named individual for provided services, regardless of insurance coverage.

Furthermore, I acknowledge that it is my responsibility to inform this office, **in writing**, when I am no longer financially responsible for the said party. This includes, but not restricted to any patient at the age of 18 years and older.

_____ _____
Signature of responsible party Date

K.C. SCHNEIDER, DDS

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