Responsibility and Consent Statement

JOSEPH LARGEMAN, D.D.S.
3830 Rosemont Drive
Columbus, GA 31904

Telephone (706) 322-6581

Date _____

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

_____ DOB:_____

_____ DOB:_____

_____ DOB:_____

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)