Responsibility and Consent Statement

The Dental Centre
OFFICE OF DR. JACK FAN, PLLC
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Austin, TX 78749
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Email:care@dentalcentreaustin.com

Date: _____

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

_____ 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 diagnosis 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.

_____ Date _____
Signature of Patient, Parent or Guardian or Personal Representative

_____ Date _____
Signature of Patient, Parent or Guardian or Personal Representative