Responsibility and Consent Statement

John Winder D.D.S., Inc.

John Winder, D.D.S. Paige Winder, D.D.S Timothy Casey, D.D.S.
501 South Washburn Street
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 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)