Responsibility and Consent Statement

Mark A. Roberts, DDS, PA
210 Crestway St. Ste 106
Athens, TX 75751
(903) 675-2122

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.

We do not guarantee that your insurance company will pay what we have estimated, therefore, you may have a balance after your insurance company pays.

I, _____ understand that I will be responsible for any amount my insurance does not pay.

When a minor patient is brought to our office, the parent that brings them in is responsible for the child's fee.

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

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Mark A. Roberts, DDS, Notice of Privacy Practices.

Patient Name: _____

Signature: _____ Date: _____