

## RESPONSIBILITY AND CONSENT STATEMENTS

Terry J. Gillespie, D. D. S.  
1700 Summit  
Red Oak, Iowa 51566  
(712)623-5404

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

\_\_\_\_\_ Age \_\_\_\_\_  
\_\_\_\_\_ Age \_\_\_\_\_  
\_\_\_\_\_ Age \_\_\_\_\_  
\_\_\_\_\_ 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 his 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.

\_\_\_\_\_ Date \_\_\_\_\_  
(Signature of Responsible Party)