

**Responsibility and Consent Statement**

**Berkeley Dental**

**Shun Hsu, DDS**

*General and Cosmetic Dentistry*

1132 Athens Hwy., Suite 207

Grayson, GA 30017

Telephone: (678) 512-0261

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 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 Patient, Parent, Guardian or Personal Representative      Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative      Relationship to Patient