McMurphy Family Dentistry

Amanda McMurphy, DMD

Date:__________________________

I hereby authorize and request the performance of dental services for myself and/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 for the above names, regardless of insurance coverage.

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Signature of Responsible Party

2318 Pass Road, Suite 9, Biloxi, MS 39531 Phone (228) 207-1548 Fax (228) 388-4696