

LISA GITELSON, DMD, PC
DAVID L. WILSON, DMD
14300 S.W. PACIFIC HWY.
TIGARD, OR 97224
(503) 639-4330

As the parent of _____ / _____,
(Patient's Name) (Birth Date)

I hereby accept responsibility for payment of any services performed by the office of Lisa Gitelson, DMD, PC, for him/her. After the course of treatment has been paid in full, and I no longer wish to accept responsibility for future treatment, I will so inform the doctor's office in writing.

(Parent/Responsible Party's Printed Name)

(Parent/Responsible Party's Signature)

(Address 1)

(Address 2)

(Date)