Gresham Smile Designs
Daniel J Ries DMD PC
1201 SE 223rd Ave., Suite 140
Gresham, OR 97030
503-665-8116

As the parent of _____, who attained age 18 on _____
(patient's name) (birth date)

I hereby accept responsibility for payment of any services performed by Dr. Daniel J Ries 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.

_____
(Signature of Parent/responsible party)

_____
(printed name of parent/responsible party)

_____
(address)

_____
(date)