



**University Dental Center**  
Cosmetic & General Dentistry, Implants

**W. HABBAL, D.D.S.**

12612 South Harlem Avenue ■ Palos Heights, Illinois 60463  
Phone: 708-361-8117

## CONSENT FORM

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with *(Name of Patient)* \_\_\_\_\_ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% finance charge (18% annually) will be added to my balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

*Patient* \_\_\_\_\_ *Date* \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*Parent of Responsibility Party* \_\_\_\_\_

## AUTHORIZATION

I authorize my insurance company to pay all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

The above information is correct to the best of my knowledge.

*Signature* \_\_\_\_\_ *Date* \_\_\_\_ / \_\_\_\_ / \_\_\_\_