

Elmhurst Family Dental
Dr. Louis A. Pahopos
585 N. York Rd.
Elmhurst, IL 60126

Responsibility and Consent Statement

Responsible Party:

Please complete the following information. Responsible party cannot be a minor.

Person responsible for account: _____

Relationship to patient: _____ Driver's License #: _____

Address: _____ Home Phone: _____

City, State, Zip: _____ Birth Date: _____

Employer: _____ Work Phone: _____

Occupation: _____ SSN: _____

Consent:

I hereby authorize and request the performance of dental services for myself or (patient's name) _____ . I also authorize the dentist, Dr. Louis Pahopos, to perform any advisable dental diagnostic procedures, and provide any medications and treatment as may be necessary to make a thorough diagnosis of my (or my dependant's) dental needs.

I authorize release of any information concerning my (or my dependant's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize the release of any information concerning my (or my dependant's) healthcare, advice and treatment to another dentist.

I authorize payment of insurance benefits directly to the dentist, otherwise payable to me.

I understand and acknowledge I am financially responsible for the services provided for myself (or my dependant) for payment in full on all accounts, regardless of insurance coverage.

Patient or Responsible Party Signature

Date