SHAHRAM SHEKIB, DDS, FAGD, PC

LASER AESTHETIC SURGERY • PORCELAIN VENEERS • INVISALIGN • IMPLANT DENTISTRY

REGISTRATION FORM

Date: _______________ Home Phone: _______________ Cell Phone: _______________ Business Phone _______________

PATIENT INFORMATION

Name _______________ SS/HIC/Patient ID# _______________

Address _______________ Email _______________

City _______________ State _______________ Zip _______________

Sex: M___ F___ Age _______ Birthdate _______________ Please Check: Minor____ Single____ Married____ Separated____ Divorced____ Widowed____

Patient Employer / School: _______________ Occupation: _______________

Employer / School Address _______________ Employer/ School Phone (_____) _______________

Whom may we thank for referring you? _______________

In case of emergency who should be notified? _______________ Phone (_______) _______________

PRIMARY INSURANCE

Person Responsible for Account _______________

Relationship to Patient _______________ Birthdate _______________ Soc. Sec. # _______________

Address (if different from patient's) _______________ Phone (______) _______________

City: _______________ State _______________ Zip _______________

Person Responsible Employed by _______________ Occupation: _______________

Business Address _______________ Business Phone (_______) _______________

Insurance Company _______________

Contract # _______________ Group # _______________ Subscriber _______________

Names of dependents covered under this plan _______________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? [Please Check One] Yes No

Subscriber Name _______________ _______________ Birthdate _______________ Relationship to Patient _______________

Address (If different from Patient's) _______________ Phone (________) _______________

City _______________ State _______________ Zip _______________

Subscriber Employed by _______________ Business Phone (________) _______________

Insurance Company _______________ Soc. Sec. # _______________

Contract # _______________ Group # _______________ Subscriber # _______________

Names of other dependants covered under this plan _______________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependant(s), have insurance coverage with _______________ and assign directly to Shahram Shekib, DDS, FAGD, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Also, I verify the above information and give my consent for treatment.

The above-named dentist may use my healthcare information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

BROKEN APPOINTMENTS AND OUTSTANDING BALANCES

In order to keep our offices functioning in a timely and organized manner, there will be a surcharge for all patients who cancel any appointments with less than 24 hours notice. Emergency cancellations will require supporting documentation. Additionally, any outstanding balances over 30 days may be subject to assessed late fees, and or reasonable attorneys' fee.

_______________ _______________

Signature of Patient, Parent, Guardian, or Personal Representative | Date

_______________ _______________

Please print name of Patient, Parent, Guardian, or Personal Representative | Relationship to Patient