Date _______________ Home Phone _________________________

Work Phone _________________________

Cell Phone/Email _____________________

PATIENT INFORMATION

Name ____ Soc. Sec # _________________________
Last Name First Name Initial

Address ____
City ____ State ___________ Zip ___________________
Sex ☐ M ☐ F Birthdate ____________ ☐Single ☐ Married ☐ Widowed ☐ Divorced
Patient Employer_________________________________Occupation______________________________
Who may we thank for referring you? ____
Emergency Contact _______________________________ Phone # ________________________________

PRIMARY DENTAL INSURANCE

Responsible Party____
Last Name First Name Initial
Relationship to Patient ___________________ Birthdate _________ Soc Sec # ______________________
Address (if different from patient's) ___________________________________ Phone
____
City ___________________________________ State ____________ Zip ____________________________
Responsible Party Employed by _____________________________________Phone _________________
Business Address ____
Insurance Company ____
Id # ___________________________________ Group # _______________________________________

ADDITIONAL DENTAL INSURANCE

Subscriber Name __________________________________ Relation to Patient______________________
Address (if different from patient's) ____
City _______________________________State _______ Zip ____________ Phone__________________
Subscriber Employer ________________________________ Phone _______________________________
Insurance Co. ____ Soc Sec # __________________________
Id # ___________________________________ Group # _______________________________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____________________
Name of Insurance Co.
And assign directly to Dr. Shamseddin 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 my insurance company. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_________________________________ ______________________________ ________________
Responsible Party Signature Relationship to Patient Date