Dr. Nastaran Ejtemai DDS.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

DATE _____

NAME _____ ☐ **MARRIED** ☐ **SINGLE** ☐ **MINOR** ☐ **MALE** ☐ **FEMALE**
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT# CITY STATE ZIP

BIRTHDATE _____ **TELEPHONE** _____
MONTH DAY YEAR HOME WORK CELL

EMAIL ADDRESS _____ **EMPLOYER** _____

ARE YOU A FULL TIME STUDENT _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐ **PATIENT** ☐ **GUARDIAN** ☐ **SPOUSE** ☐ **FATHER** ☐ **MOTHER**

INSURANCE INFORMATION	MINOR CHILD – MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION ADULTS – COMPLETE PRIMARY INSURED DUAL COVERAGE? - ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED
IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO.

SS# SUBSCRIBER# GROUP#

SECONDARY INSURED

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO.

SS# SUBSCRIBER# GROUP#

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

Has any member of your family ever been treated in our office?

☐ Yes ☐ No

Whom may we thank for referring you to our office?

_____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
Patient or Responsible Party

_____
Date