Smile Center

Mehdi Sadeghi, D.D.S.
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Memphis, Tennessee 38138
Phone (901) 309-1333 • Fax (901) 309-1422
smilecentermemphis.com

DATE: _____

PATIENT INFORMATION
(Please Print)

Patient Name _____ Date of Birth _____ Sex _____
Address _____ City/State _____ Zip _____
Home Phone _____ Marital Status _____ S.S.# _____
E-mail Address _____ Cell # _____
Preferred Appointment Time and Day _____
Occupation _____ Employer _____
Business Address _____ Business Phone _____
Spouse s Name _____ Phone _____ S.S.# _____
Occupation _____ Employer _____
Business Address _____ Business Phone _____
Nearest Relative Not Living With You _____ Phone _____
Address _____ City/State _____ Zip _____
Whom To Notify In Case Of Emergency _____ Phone _____
Relationship _____
Chief Dental Complaint _____
Are You Interested In Getting All Dental Work Done or Just One Specific Problem? _____
Former Dentist _____ Date Of Last Dental Visit _____
Are You Active In Any Organized or Recreational Sports Activities? _____
Whom May We Thank For Referring You? _____

Primary Dental Ins. _____ Subscriber s Name _____ D.O.B. _____
ID # _____ Group # _____ Phone # _____
Address _____ City/State _____ Zip _____
Secondary Dental Ins. _____ Subscriber s Name _____ D.O.B. _____
ID # _____ Group # _____ Phone # _____
Address _____ City/State _____ Zip _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. ***It is your responsibility to pay any deductible, co-insurance, or any other balance not paid for by your insurance company.*** **In order to control cost of billing, we request that your co-payment be paid at the conclusion of each visit.**

Insurance Authorization and Assignment
I hereby authorize Mehdi Sadeghi, D.D.S. to furnish information to my insurance company concerning my dental condition and treatments and I hereby assign to the dentist all payments for dental services rendered to myself and for my dependents. In the event of default, patient is responsible for all costs of collection agency fees, attorney fees, and court costs. **I understand that I am responsible for any amount not covered by insurance.**

Date _____ Signature _____
patient signature (parent/guardian if minor)

Preferred Method Of Payment: Cash ☐ Check ☐ Credit Card ☐