Smile Center

Mehdi Sadeghi, D.D.S.
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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. **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 ☐