Smile Center

Mehdi Sadeghi, D.D.S.
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DATE: _____ PATIENT # _____

PATIENT INFORMATION
(Please Print)

Patient Name _____ Date of Birth _____ Sex _____
Address _____ City/State _____ Zip _____
Home Phone _____ School Name _____ Grade _____
Patient Lives With: ☐ Father ☐ Mother ☐ Both ☐ Other _____
Father's Name _____ Phone _____ D.O.B. _____
Address _____ S.S. # _____
Occupation _____ Employer _____
Business Address _____ Business Phone _____
Dental Ins. Co. _____ Group # _____
Address _____ City/State _____ Zip _____
Mother's Name _____ Phone _____ D.O.B. _____
Address _____ S.S. # _____
Occupation _____ Employer _____
Business Address _____ Business Phone _____
Dental Ins. Co. _____ Group # _____
Address _____ City/State _____ Zip _____
Person Responsible For Account _____ Address _____
Whom To Notify In Case Of Emergency _____ Phone _____
Nearest Relative Not Living With You _____ Phone _____
Address _____ City/State _____ Zip _____
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? _____

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 child's 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 _____ Parent or Guardian Signature _____

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