

# Smile Center

Mehdi Sadeghi, D.D.S.

6750 Poplar Ave., Suite 612 (Forum I)  
Memphis, Tennessee 38138  
Phone (901) 309-1333 • Fax (901) 309-1422

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