

# PATIENT REGISTRATION

## PATIENT INFORMATION

PATIENT'S NAME Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ SEX: \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ FT Student: Y N If yes, Where: \_\_\_\_\_

Whom May We Thank for Referring You to our Office? \_\_\_\_\_

RESIDENCE Street \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If Different from Above:

MAILING ADDRESS Street \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

EMAIL \_\_\_\_\_ May we Text you Appointment Reminders: \_\_\_\_\_ YES \_\_\_\_\_ NO

SOCIAL SECURITY # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_

EMPLOYER \_\_\_\_\_ Phone Number \_\_\_\_\_

### CANCELLATION POLICY

We aim to provide our clients the highest quality service and pride ourselves on our exceptional team. If you should cancel or reschedule your reserved appointment less than 24 hours before your schedule appointment time, we not only lose your business, but also the potential business of other clients who may have taken your scheduled time. For this reason we are obligated to compensate our team for their time and well as make up for lost revenue. After 2 occurrences, we will require you to pay a \$100 deposit to schedule another appointment. This \$100 will be applied to your treatment the day of the scheduled appointment. Patients who no show an appointment will be charged \$50.00

Please initial that you have read and understand the policy \_\_\_\_\_

### EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

HOME PH. \_\_\_\_\_ CELL PH. \_\_\_\_\_

WORK PH. \_\_\_\_\_

### DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name \_\_\_\_\_

Insurance Co. \_\_\_\_\_ E-MAIL \_\_\_\_\_

Insurance Co. Phone \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_

Insured's Soc. Sec. # \_\_\_\_\_ Group # \_\_\_\_\_ ID# \_\_\_\_\_

If you have secondary dental insurance coverage, complete this for the second coverage.

Insured's Name \_\_\_\_\_

Insurance Co. \_\_\_\_\_ E-MAIL \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's Soc. Sec. # \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance cover with the above named insurance company and assign directly to Dr. Jason Daaboul all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. This assignment and release will apply to any new insurance provided to the office in the future

Dr. Jason Daaboul may use my health care information and may disclose such information to the above-names insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The Doctors also have my consent to use any photos taken without identifying information or full face, for use in journals, office use, website, and other advertising.

PATIENT Signature (Parent of Child) \_\_\_\_\_ Date: \_\_\_\_\_ DENTIST Signature \_\_\_\_\_