

# SHAHRAM SHEKIB, DDS, FAGD, PC

LASER AESTHETIC SURGERY • PORCELAIN VENEERS • INVISALIGN • IMPLANT DENTISTRY

## REGISTRATION FORM

Date: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

### PATIENT INFORMATION

Name \_\_\_\_\_ SS/HIC/Patient ID# \_\_\_\_\_

Address \_\_\_\_\_ Email \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex: M \_\_\_ F \_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Please Check: Minor \_\_\_ Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_

Patient Employer / School: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer / School Address \_\_\_\_\_ Employer/ School Phone (\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

### PRIMARY INSURANCE

Person Responsible for Account \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber \_\_\_\_\_

Names of dependents covered under this plan \_\_\_\_\_

### ADDITIONAL INSURANCE

Is patient covered by additional insurance? [Please Check One] Yes No

Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address (If different from Patient's) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Names of other dependants covered under this plan \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependant(s), have insurance coverage with \_\_\_\_\_ and assign directly to Shahram Shekib, DDS, FAGD, PC 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. Also, I verify the above information and give my consent for treatment.

The above-named dentist may use my healthcare information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

### BROKEN APPOINTMENTS AND OUTSTANDING BALANCES

In order to keep our offices functioning in a timely and organized manner, there will be a surcharge for all patients who cancel any appointments with less than 24 hours notice. Emergency cancellations will require supporting documentation. Additionally, any outstanding balances over 30 days may be subject to assessed late fees, and or reasonable attorneys' fee.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian, or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian, or Personal Representative

\_\_\_\_\_  
Relationship to Patient