# Office of Sally Kashani DDS Patient Information

Date:___________

Please complete this confidential information sheet in its entirety at time of visit/treatment

Name_______________________________________________________ M F Social Security #___________________________

Last First MI

Drivers License #______________________ Birth date____________________ Age__________

Home Phone_______________________Work Phone_______________________Cell phone_____________________

Email:________________________________

Mailing Address______________________________________________City____________________State_________Zip
_________________________________________________________________________________

Employer and Address
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Spouse/Parent Name____________________________Phone_____________________Social Security #
____________________________________________________________________

Spouse Employer and Address
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Who may we thank for referring you to this office?__________________________________________Phone________________________

***IN CASE OF EMERGENCY:***

Relative or Emergency Contact ______________________________________________________Phone________________________

***1. DENTAL INSURANCE (please provide membership card if available)***

Name of Insured/Employee__________________________________________ Birth date______________________________________

Month/Day/Year

Employer___________________________________________________Employee SSN/ID #___________________________________

Insurance Company_________________________________________Policy/Group #_______________________________________

Claims Address__________________________________________________________________________________________

***If someone other than the PATIENT is responsible for payment, complete the following:***

Name of responsible party_______________________________Address____________________________________________________

Phone________________________________Social Security #________________________Relationship to Patient____________________

***Please sign and return to receptionist.***

<u>**FINANCIAL AGREEMENT**</u>: The undersigned agrees, whether he/she signs as an agent or as a patient, that in consideration of the services to be rendered to the patient: I hereby individually obligate myself to pay the account in accordance with the fees and terms of the Dental Office whether or not they are covered by insurance. Should the account be referred to an attorney for collection for this visit or any other, the undersigned shall pay all reasonable costs and expenses including attorney's fees and collection expense.

<u>**INSURANCE RELEASE**</u>: I hereby authorize Sally Kashani DDS to furnish to the above named insurance company all treatment and x-ray information which said insurance company may request. I hereby authorize payment to be made directly to the Dental Office but not to exceed the charges incurred.

Signature__________________________________________________________________Date_________________________________