Dental Implant Centers

CONFIDENTIAL PATIENT REGISTRATION

First Name: ____________________________ Last: _____________________________________Middle: _________________ Sex: M F

Birth Date: ____/____/____ SSN #: ____________________ Drivers License #: ___________________ Height: _______ Weight: _____

Marital Status: Married Single Separated Divorced **Email Address**: ____

Home Phone #: __________________________Work Phone #: ________________________ Cell Phone #: ______________________

Address: ____ _________ _____________________________ _______ _____________
Street Apt. # City State Zip Code

Employer Info: ____
Name Street Address City State Zip code

Dental Insurance Information:

Primary Insurance: ____________________________________Group #: ____________________ Phone #: ________________________

Secondary Insurance: __________________________________Group #: ____________________ Phone #: ________________________

Subscriber's First Name: _____________Last: ________________ Middle: __________ Birth Date: ____/___/____ SSN #:__________

Nearest Relative Not Living With You: Fist Name: ___________________ Last: ______________________ Relation: ____________

Address: _____________________________________ _____ ____________________ ______ _________ ________________________
Street Apt. # City State Zip code Phone Number

Responsible Party:

First Name: _______________________ Last: ___________________________ Middle: ___________________ Relation: ___________

Birth Date: ____/___/______ SSN #: ________________________________ Drivers License #: ________________________________

Address: ____
Street Apt. # City State Zip Code

Home Phone #: _______________ Work Phone #: _______________ Cell Phone #: _______________Email Address: ______________

Employer Info: ____
Name Street Address City State Zip code

How did you hear about us? Phone Book Google Yahoo MSN Magazine Drive by Other___________________

Notice of Responsibility: I understand that I am personally responsible for the cost of my dental care based on Dr. Khazian's fee schedule. I agree to pay accordingly, at the time of service, (unless otherwise pre-arranged) for any dental treatment rendered by this office. It has been explained to me that this office is not responsible for my dental insurance benefits and, that my dental insurance may have different fee schedule which may be lower than Dr. Khazian's. I further understand that this office will bill my dental insurance, only as a courtesy, and by no means, whatsoever, is responsible for the amount my insurance will pay.
Notice of Privacy Practices: I, __________________________________ hereby acknowledge that I have received a copy of Dental Implant Centers Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this notice.

Signature of Patient (or parent/guardian if patient is a minor) _____________________________________**Date**______________