Nima Mashkouri, DMD

Thomas R. Feder, DDS

PATIENT REGISTRATION

ID: ____________ Chart ID: ____________________

First Name: ____________________ Last Name: ____________________ Middle Initial: _____

Patient is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: ____________________

Responsible Party (if someone other than the patient)

First Name: ____________________ Last Name: ____________________ Middle Intial: _______

Address: ____________________ Addresss 2: ____________________

City, State, Zip ________________________________ Pager: ____________

Home Phone: ____________ Work Phone: ____________ Ext: _____ Cell: ____________

Birth Date: ____________ Soc. Sec.: ____________ Driver's License: ____________

◯ Responsible Party is also Policy Holder ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: ____________________ Addresss 2: ____________________

City: ____________ State ______ Zip ____________ Pager: ____________

Home Phone: ____________ Work Phone: ____________ Ext: _____ Cell: ____________

Sex: ◯ Male ◯ Female

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Email: ____________ ☐ I would like to receive correspondence via e-mail

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: ____________ Pref. Denist: ____________

Employer ID: ____________ Pref. Pharmacy: ____________

Caller ID: ____________ Pref. Hyg. ____________

Section 3

Cell: ____________

Visa: ____________

M.C.: ____________

FMX: ____________

Bridge: ____________

Visa Exp.: ____________

M.C. Exp: ____________

Primary Insurance Information:

Name of Insured: ____________________ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec.: ____________________

Employer ____________________

Address: ____________________

Address 2: ____________________

City/State/Zip ____________________

Rem. Benefits: ________.00 Rem. Deduct ________.00

Insured Birth Date: _____/_____/________

Ins. Company ____________________

Address: ____________________

Address 2: ____________________

City/State/Zip ____________________

Secondary Insurance Information:

Name of Insured: ____________________ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec.: ____________________

Employer ____________________

Address: ____________________

Address 2: ____________________

City/State/Zip ____________________

Rem. Benefits: ________.00 Rem. Deduct ________.00

Insured Birth Date: _____/_____/________

Ins. Company ____________________

Address: ____________________

Address 2: ____________________

City/State/Zip ____________________

PATIENT REGISTRATION
(Continued)

Patient Name: ____

CONSENT:

1. I hereby authorize doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with patient. I understand that using anesthetics agents embodies a certain risk.
3. I authorize doctor to choose and employ such assistance as deemed fit to provide recommended treatment.
4. I authorize release of information relating to patient's care to the appropriate insurance carrier or other health care providers.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.

Signature of Patient, Parent or Guardian:

____Date:__________________

AUTHORIZATION TO BILL INSURANCE:

1. I authorize doctor to bill my insurance on behalf of patient.
2. I authorize payment of the dental benefits otherwise payable to me directly to the doctor.

Signature of Insured:

____Date:__________________

AGREEMENT TO PAY:

1. I understand that all responsibility for payment for dental services provided in this office for patient is due and payable at the time services are rendered unless other arrangements have been made.
2. I understand that, where appropriate, credit bureau reports may be obtained.
3. I understand that in the event patient's insurance coverage is not effective, or any services are not covered, I will be financially responsible for any services rendered.

☐ I understand that The Women's Breakfast Club of Santa Monica, through the Boys and Girls of Santa Monica has agreed to take responsibility for payment for dental services provided for my child by this office.

Signature of Responsible Party:

____Date:__________________