

RAMIN SHABTAIE, D.D.S., INC.
Patient Information

The following information is for our records only:

Patient _____ Mr. Mrs. Ms. Dr.
Last First Initial

Age _____ Date of Birth _____ Marital Status _____

Social Security Number _____ Driver's License Number _____ State _____

Home Address _____ Home Phone _____

City _____ State _____ Zip _____

E-mail Address _____

Patient's Occupation _____

Patient Employed By _____ Business Phone _____

Employer's Address _____

Spouse/Guardian's Name _____

Spouse/Guardian Employed By _____ Business Phone _____

Party Responsible For This Account _____

Social Security Number _____ D.O.B. _____ Driver's License Number _____

Name of Closest Relative _____ Phone _____

Relative's Address _____ Relationship _____

Patient's Physician _____ Phone _____

Physician's Address _____

How did you find our office? Dentist Referral Friend/Family Insurance Referral Internet Other: _____

Referred By _____

Patient's Dentist _____

Dentist's Address _____

Primary Dental Insurance Co. _____ Policy # _____

Secondary Dental Insurance Co. _____ Policy # _____

Primary Medical Insurance Co. _____ Policy # _____

Secondary Medical Insurance Co. _____ Policy # _____

To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES. We will prepare the necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay our fees.

Purpose of This Visit _____

Signature _____ Date _____