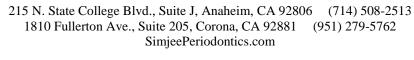
Patient Information

Last Name		Fi	rst Name)		Mic	ddle Initial
Gender: O Male Birth Date		•	O Single	O Married	O Widowed	O Divorced	O Child
S.S. #		CA Driv	ers Licens	e # or ID #_			
Home #		Cell #		· · · · · · · · · · · · · · · · · · ·	Work	#	
Email Address			_ Best time	e and # to c	ontact you: _		
Home Address				City			Zip
Employer (Compa	ny name)				Occupa	tion	
Business Address				City			Zip
Dental Insurance _				Subscribe	r		Group#
Medical Insurance				Subscriber	•		Group#
(Relationship to pati Birth Date S.S. #							
Home #		Cell #			Work	#	
Employer (Compa	ny name)				Occupa	tion	
Business Address_				City			Zip
Dental Insurance _				Subscribe	r		_ Group#
Medical Insurance				Subscriber			Group#
Who do we contac	ct in case of an en	nergency? _					
Relation to Patien	t	Number to call:					
			(Continue	d on back)		_	INITIAL HERE
							Page 1 of 3





Insurance Information

Primary Dental Ins	surance		
,		Primary Dental Insurance Name	
Subscriber Name:		Relation to Patient:	
Subscriber Birth Date:	Subscriber SS#:	Subscriber Drivers License #	
Subscriber Employer Name:			
Secondary Dental	Insurance	Primary Dental Insurance Name	
Subscriber Name:		Relation to Patient:	
Subscriber Birth Date:	Subscriber SS#:	Subscriber Drivers License #	
Subscriber Employer Name:			
Primary <i>Medical</i> Ir	nsurance	Primary Dental Insurance Name	
		Pfilmary Denial insurance mame	
Subscriber Name:		Relation to Patient:	
Subscriber Birth Date:	Subscriber SS#:	Subscriber Drivers License #	
Subscriber Employer Name:			
Secondary Medica	al Insurance	Primary Dental Insurance Name	
Subscriber Name:		·	
Subscriber Birth Date:	Subscriber SS#:	Subscriber Drivers License #	
Subscriber Employer Name:			

(Continued on next page)

- The information I have provided in this form is correct to the best of my knowledge.
- I understand that the treatment recommended is based on Dr. Simjee's professional judgment with respect to my long term best interest.
- I understand that fee estimates for any treatment are valid for 6 months from the date of patient examination.
- I understand that complete payment for dental services provided in this office for my dependents or me is due and payable at the time services are rendered (unless other provisions have been made in writing), and ultimately, I am responsible for any treatment not paid for by insurance. In the event payments are not received by the agreed upon dates, a 1% per month (12% per annum) will be added to my account, in addition to any collection charges. Unpaid balances will be sent to collections after 90 days.
- I understand that my insurance carrier has limitations in coverage.
- I understand that any estimate of my insurance coverage is only an estimate and not a guarantee of payment.
- I understand that insurance payment may be reduced by deductibles, coordination of benefits with another carrier, expenses that may be paid before these services are rendered and my claim is submitted and other plan limitations in effect when services are actually performed.
- I hereby authorize payment of insurance benefits (otherwise payable to the patient) directly to Rasheed Simjee, Professional Dental Corporation.
- I authorize the use of my social security number to submit all insurance claims as a courtesy to me.
- I understand that any surgery appointments canceled within 72 hours of appointment time will require a \$250 deposit to reschedule the appointment. This amount will be used towards my copayment or will be refunded after insurance pays in full.
- I understand that I will be charged \$25 for any returned checks.
- I understand that where appropriate, credit bureau reports may be obtained.
- I understand that a paper or electronic copy of this document may act as an original.

I,Patient, Parent, or Guardian (please print)	agree to the policies of this office set forth above.	
Relation to patient		
Signature	Date	
	We look forward to meeting you.	
	story rivacy Practices communication	