Patient Information

Last Name_____ First Name_____ Middle Initial_____

Gender: ☐ Male ☐ Female Family Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Child

Birth Date_____

S.S. #_____ CA Drivers License # or ID #_____

Home # _____Cell # _____ Work # _____

Email Address_____ Best time and # to contact you: _____

Home Address_____City_____Zip_____

Employer (Company name) _____Occupation_____

Business Address_____City_____Zip_____

Dental Insurance _____ Subscriber _____ Group# _____

Medical Insurance_____ Subscriber _____ Group# _____

Information for Financially Responsible Party (If other than self)

Last Name _____First Name _____

(Relationship to patient): ☐ **Spouse** ☐ **Parent** ☐ **Legal Guardian** ☐ **Other** _____

Birth Date_____

S.S. #_____ CA Drivers License # or ID #_____

Home # _____Cell # _____ Work # _____

Employer (Company name) _____Occupation_____

Business Address_____City_____Zip_____

Dental Insurance _____ Subscriber _____ Group# _____

Medical Insurance_____ Subscriber _____ Group# _____

Who do we contact in case of an emergency? _____

Relation to Patient _____Number to call: _____

(Continued on back)

INITIAL HERE _____

215 N. State College Blvd., Suite J, Anaheim, CA 92806 (714) 508-2513
1810 Fullerton Ave., Suite 205, Corona, CA 92881 (951) 279-5762
SimjeePeriodontics.com

REVISED
12:45 pm, Jun 01, 2011

Insurance Information

Primary Dental Insurance _____
Primary Dental Insurance Name

Subscriber
Name:_____ Relation to Patient:_____

Subscriber Subscriber Subscriber
Birth Date: _____ SS#: _____ Drivers License # _____

Subscriber
Employer Name:_____

Secondary Dental Insurance _____
Primary Dental Insurance Name

Subscriber
Name:_____ Relation to Patient:_____

Subscriber Subscriber Subscriber
Birth Date:_____ SS#: _____ Drivers License # _____

Subscriber
Employer Name:_____

Primary *Medical* Insurance _____
Primary Dental Insurance Name

Subscriber
Name:_____ Relation to Patient:_____

Subscriber Subscriber Subscriber
Birth Date:_____ SS#: _____ Drivers License # _____

Subscriber
Employer Name:_____

Secondary *Medical* Insurance _____
Primary Dental Insurance Name

Subscriber
Name:_____ Relation to Patient:_____

Subscriber Subscriber Subscriber
Birth Date:_____ SS#: _____ Drivers License # _____

Subscriber
Employer Name:_____

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- 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, _____ agree to the policies of this office set forth above.
Patient, Parent, or Guardian (please print)

_____
Relation to patient

_____ _____
Signature Date

We look forward to meeting you.

For Office Use Only:

_____Patient Information
_____Health History
_____Patient Privacy Practices
_____Internet Communication
_____Insurance Card(s)