

Ralph Sahakian D.M.D., P.C.

Welcome to Our Office!

Patient Information (CONFIDENTIAL)

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Email: _____

Social Security Number: _____ - _____ - _____ (optional) Check One: _____ Minor _____ Single _____ Married

Person to Contact in Case of Emergency: _____ Phone: _____

Whom May We Thank for Referring You? _____

Dental Insurance Information **Please Present Your Insurance Card**

Name of Insured: _____ Date of Birth: _____

Relationship to Patient: _____ SS#: _____

Employer: _____

Insurance Company: _____ Group Number: _____

Do you have additional dental insurance? _____ If yes, please present card at time of visit.

Name of Insured: _____ Date of Birth: _____

Relationship to Patient: _____ SS#: _____

Employer: _____

Insurance Company: _____ Group Number: _____

Authorization and Release

I certify that I have read and understand the above information and that I have accurately answered the above questions to the best of my knowledge. I authorize the dentist to release any information to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient, parent, or guardian **X** _____

Over Please →

Scanned _____