

WELCOME TO OUR OFFICE

Who may we thank for referring you?

Thank you for selecting us as your dental health team. In order to give optimum service, it is necessary to become acquainted with vital information specific to you. Therefore, please complete to following. Feel free to ask for assistance.

Legal Name (Mrs. Mr. Ms.) _____ (_____) _____ **Date of birth** _____, _____, _____
First Preferred Last Mo Day Year

Mailing/home address _____
Apt # Street City Prov. P. Code

Contact #'s _____, _____, _____ (OK to call _____)
Preferred # Home Cell E,mail Work Ext

Person financially responsible for account: Name _____ Employer _____

Address (if different than above) _____

Contact #'s (if different than above) _____
Home Cell Work Ext Email

Dental Insurance Information

My Primary coverage is: _____ M____ D____ Y____
Name of Policyholder Date of birth Employer Insurance Company

Group/Policy# ID/Certificate # M____ D____ Y____ Deductible \$____ \$____ %____
Effective date /person /family Preventive Basic Major Ortho

The policy limits/exclusions are: _____

My Secondary coverage is: _____ M____ D____ Y____
Name of Policyholder Date of birth Employer Insurance Company

Group/Policy# ID/Certificate # M____ D____ Y____ Deductible \$____ \$____ %____
Effective date /person /family Preventive Basic Major Ortho

The policy limits/exclusions are: _____

I _____ hereby assign my dental benefits payable directly, and authorize the insurance company(s) above to provide details of my benefits and claims to the office of Dr. Ali Behmard.

Signature: _____

I understand that my insurance benefits are not necessarily based on my individual needs and that the optimal treatment required may not be covered by my group benefits. I accept responsibility to be aware of any limits and/or exclusions in my policy and acknowledge that credit will be extended to me on the estimated assigned portion for a maximum of 60 days. The balance of any outstanding claims not paid on my behalf 60 days from the date of service may be charged to the following credit card:

Mastercard/Visa _____ expiry _____ **Signature:** _____

As appointment times are reserved just for you, failure to attend, or provide us with adequate notice delays your necessary dental treatment and does not allow us to offer other patients access to treatment, some of which may be of an urgent nature.

I understand that 48 business hours (2 weekdays) notice is required to change or reschedule an appointment reserved for me or my dependents and that I will be charged the customary fee of \$75.00 per hour of reserved time for a short notice cancellation or missed appointment.

I certify that all of the above information is true and no pertinent information has been omitted. I hereby authorize the dental office to take x-rays, and diagnostic aids necessary to make a thorough assessment of my dental needs. I consent to the performing of dental procedures as agreed upon with the Doctor to be necessary & advisable. I understand that with each dental treatment the possibility of complication exists. I accept that payment for all treatment for me or my dependents remains my responsibility and payment is due at the time treatment is rendered, unless other financial arrangements are confirmed prior to the start of treatment.

Signature _____

Parent/Guardian _____ **Date** _____