GENTLE ENDODONTICS OF KENT

Vahid A. Atabakhsh, DDS

Thank you for choosing us for your dental care needs. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to contact us. (253) 850-6999

PATIENT INFORMATION

Patient Name: _____ Social Security #: _____
(Last name) (First name) (Middle Initial)

Birth Date: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Minor

Driver's License #: _____ State: _____ Email Address: _____

Street Address: _____ City _____ State _____ Zip _____

How long at present address? _____ Home Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Work Phone: _____

DENTAL INSURANCE

Individual responsible for this account:

_____
(Last name) (First name) (Middle Initial)

Relationship to Patient _____

Birth Date _____ Soc. Sec # _____

Street Address _____

City _____ State _____ Zip _____

Home Phone: _____Work Phone: _____

Responsible Party Employed by: _____

Insurance Company _____

Subscriber ID# _____ Group # _____

ADDITIONAL INSURANCE

Individual responsible for this account:

_____
(Last name) (First name) (Middle Initial)

Relationship to Patient _____

Birth Date _____ Soc. Sec # _____

Street Address _____

City _____ State _____ Zip _____

Home Phone: _____Work Phone: _____

Responsible Party Employed by: _____

Insurance Company _____

Subscriber ID# _____ Group # _____

Whom may we thank for referring you to us? _____

IN CASE OF EMERGENCY CONTACT:

Name: _____ Relationship to You: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

ASSIGNMENT AND RELEASE

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other dental insurance" is indicated on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. **Payment is due in full at time of treatment unless prior arrangements have been approved.**

Signature: _____ **Date:** _____