WELCOME TO OUR OFFICE

Royal Dental Practice

Roya Shoffet-Yaghoubian, D.M.D., D.D.S.
Family & Cosmetic
Dentistry

TODAY'S DATE _____

REVISED DATE _____

REFERRED BY _____

IN ORDER TO SERVE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION.
ALL INFORMATION IS STRICTLY CONFIDENTIAL. PLEASE PRINT CLEARLY.

PATIENT'S NAME_____ BIRTHDATE_____
(Last) (First) (Middle) (Nickname) (Month, Date, Year)

SOCIAL SECURITY # _____ MARITAL STATUS_____

ADDRESS_____
(Street) (City) (Zip Code)

HOME PHONE (Area Code) _____-_____ WORK PHONE (Area Code) _____-_____ CELL PHONE (Area Code) _____-_____

EMAIL ADDRESS _____@_____ EMPLOYER _____

EMPLOYER'S ADDRESS _____
(Street) (City) (Zip Code)

NAME OF SPOUSE (OR PARENT) _____ ADDRESS_____

SOCIAL SECURITY # OF SPOUSE _____ PHONE (Area Code) _____-_____

CHIEF COMPLAINT / REASON _____

DATE OF LAST GENERAL PHYSICAL EXAM _____
(Month - Year)

LIST ANY ALLERGIES YOU HAVE (DRUGS, FOOD, HAY FEVER, OTHER) _____

LIST ANY MEDICATIONS YOU ARE TAKING _____

DESCRIBE ANY CONDITIONS WE SHOULD KNOW ABOUT _____

DO YOU HAVE HIGH BLOOD PRESSURE? _____ DIABETES_____

PRIMARY INSURANCE COMPANY _____ POLICY # _____

SUBSCRIBER NAME _____ SOCIAL SECURITY # _____

DO YOU HAVE INSURANCE THROUGH YOUR EMPLOYER? _____ IF YES, I.D. # _____

GROUP # _____

ANY SECONDARY INSURANCE? _____ IF YES, COMPANY _____

ADDRESS TO SEND CLAIM _____

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME. INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS

Signed _____ Date _____
(Patient, or Parent if Minor)

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

Signed _____ Date _____
(Patient, or Parent if Minor)