Serene Dental
Azita Shahgaldi, DMD

Patient Form

Patient Information

Date: _____ Patient ID (SSN): _____

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Age: _____ Birthday: _____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

☐ Minor ☐ Partnered for _____ years

Occupation: _____

Employer/School: _____

Employer/School Address: _____

City: _____ State: _____ Zip: _____

Spouse's Name: _____

Spouse's Birthday: _____ Spouse's SSN: _____

Spouse's Employer/School: _____

Whom may we thank for referring you? _____

Contact Information

Home: (____) _____

Work: (____) _____ Ext: _____

Cell: (____) _____

Email: _____

Spouse's Work: (____) _____ Ext: _____

Spouse' s Cell: (____) _____

Spouse' s Email: _____

In **Case of Emergency**, whom may we contact?

(Please specify someone outside your household)

Name: _____

Relationship: _____

Home: (____) _____

Work: (____) _____ Ext: _____

Cell: (____) _____

Dental Insurance Information

Name of Insurance Plan Subscriber: _____ Relationship to Patient: _____

Insurance Company Name: _____ Group Number: _____

Subscriber Birthday: _____ Subscriber SSN: _____

☐ Yes ☐ No Are you covered by additional insurance?

Name of subscriber for additional coverage: _____ Relationship to Patient: _____

Insurance Company Name: _____ Group Number: _____

Subscriber Birthday: _____ Subscriber SSN: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above named insurance company(ies) and assign directly to Serene Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions whether manual or electronic.

Serene Dental may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Acknowledgement: Receipt of Notice of Privacy Practices

☐ I acknowledge I have received a copy of this office's Notice of Privacy Practices.

Print Name	Signature	Date	Relationship to Patient

Area Below For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Communications barriers prohibited obtaining the acknowledgement ☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Individual refused to sign ☐ Other (please specify): _____