Mahnaz Tayarani (RDHAP)
In-home dental hygiene services

PATIENT INFORMATION FORM

Patient Name (Mr. / Mrs./ Ms.): _____ DOB: _____ SS#: _____

If applicable, responsible party: _____

Home / Facility Address: _____

Spouse's name: _____ Home Phone: _____

Cell Phone: _____ Email: _____

Whom may we thank for referring you to our practice?

□ Friend, □ Facility, □ Physician, □ Dentist, □ Other

Primary/Dental Insurance Information:

Name of Subscriber: _____ Relationship: _____

Name of Insurance Co._____ SS# of subscriber: _____

Phone # of Ins. Co: _____ Group #: _____ DOB of subscriber: _____

Who should we contact in case of emergency?

Name: _____Phone: _____

Email: _____

Address: _____ Relationship: _____

Who is financially responsible for your bill?

Name: _____ Phone: _____

Address: _____

I will be paying for services by: □ CASH, □ CHECK, □ PAYPAL, □ INSURANCE

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on **both sides** of this sheet and have completed the above answers. I certify this information to be true and correct to the best of my knowledge. I will notify you of any changes in my health or any changes in the above information.

Signature: _____ Date: _____

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