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| 1 ABOUT YOU |
| Today’s Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **MI**: \_\_\_\_\_\_\_  **Preferred Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ○Male ○Female **Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Birthdate**: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ **SS#**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Occupation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City State Zip  **Home #**:(\_\_\_)\_\_\_\_\_\_-\_\_\_\_\_\_\_\_  **Work #**:(\_\_\_)\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ **Cell #**:(\_\_\_)\_\_\_\_\_\_-\_\_\_\_\_\_\_\_  **Status**: **○** Minor **○** Single **○** Married **○** Divorced **○** Separated **○** Widowed  **Emergency Contact**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Home Phone**: (\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ **Cell Phone**: (\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ |

**WELCOME** Shahin Mahallati, DDS

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| 2 Insurance Information | |
| **Primary Dental Insurance**  **Ins Company**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Phone #**: (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_  **Claim Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City State Zip  **ID#**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group#** (plan, local policy #): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Insured’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **DOB:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ **Relation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Insured’s Employer**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Secondary Dental Insurance**  **Ins Company**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Phone #**: (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_  **Claim Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City State Zip  **ID#**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group#** (plan, local policy #): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Insured’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **DOB:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ **Relation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Insured’s Employer**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |