|  |
| --- |
| 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

|  |
| --- |
| 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**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |