Smile San Clemente

Shahin Mahallati, DDS

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:** (_____)_____-_____

2. INSURANCE INFORMATION

Primary Dental Insurance

Ins Company: _____

Phone #: (_____)_____-_____

Claim Address:_____

_____

City State Zip

ID#:_____

Group# (plan#, local policy #)**:**_____

Subscriber's Name: _____

DOB: _____/_____/_____ **Relation:** _____

Subscriber's Employer:_____

Secondary Dental Insurance

Ins Company: _____

Phone #: (_____)_____-_____

Claim Address:_____

_____

City State Zip

ID#: _____

Group# (plan#, local policy #)**:** _____

Subscriber's Name:_____

DOB: _____/_____/_____ **Relation:**_____

Subscriber's Employer:_____