

Patient Information Form

(please complete & return to receptionist)



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NAME: Last, First, Middle		<input type="checkbox"/> Male <input type="checkbox"/> Female		TODAY'S DATE
ADDRESS: Street or PO Box		City	State	Zip
PHONES: Home	Cellular	EMAIL ADDRESS		
AGE	BIRTH DATE	DRIVER'S LICENSE #	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Separated	SOCIAL SECURITY NO.
OCCUPATION	EMPLOYER	HOW LONG EMPLOYED	WORK PHONE NUMBER	
Guarantor Name	GUARANTOR BIRTH DATE	GUARANTOR HOME ADDRESS IF DIFFERENT		
GUARANTOR SOCIAL SECURITY NO.	GUARANTOR WORK ADDRESS			
GUARANTOR HOME PHONE NUMBER	GUARANTOR EMPLOYER	HOW LONG EMPLOYED	WORK PHONE NUMBER	

Insurance Information

INSURED PERSON'S FULL NAME		DATE OF BIRTH
SOCIAL SECURITY NO.	RELATIONSHIP TO PATIENT	WORK PHONE
INSURANCE COMPANY NAME	GROUP OR UNION NAME	GROUP, LOCAL NO., OR PLAN NO.
EMPLOYER'S NAME	FULL ADDRESS OF INSURANCE COMPANY	
DO YOU HAVE OTHER DENTAL INSURANCE		

Getting To Know You

- 1) Why did you come to our office? _____

- 2) Who referred you to our office? _____
- 3) Is there another member of your family or relative a patient in our practice? _____
- 4) Person to contact in case of emergency: _____
 Relationship: _____
 Phone: _____

Payment

If you have dental insurance, we want you to receive the full benefit of it. Our office staff can assist you in completing your insurance forms and verifying the coverage your particular plan provides. We accept assignment of your insurance payment, another service to you. This means that you are responsible for your deductible and the portion that your insurance does not cover. Remember, however, that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.

The undersigned, hereby authorizes the release of any information relating to all claims or benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned has personally signed the particular claim until this authorization is revoked in writing.

Arbitration

It is understood that any dispute as to dental malpractice will be determined by submission to arbitration as provided by California law and not by a law suit. Both parties are giving up their constitutional rights to have such dispute decided in a court of law before jury.

For All Patients

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent to the doctor choosing and employing such assistance as he deems fit. I also understand that prior to treatment, a full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office. I also consent to the use of periodic appointment reminder phone calls and appointment reminder items sent via mail. I also understand that should my account become delinquent, my information may be released to a third party collection agency to assist with collecting fees associated with the treatment rendered.

SIGNATURE OF RESPONSIBLE PARTY

RELATIONSHIP

DATE