Nima Mashkouri, DMD

NIMA
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DMD

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Phone (310) 458-8811 - Fax (310) 458-6651

PATIENT REGISTRATION

ID: _____

Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE PATIENT)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Birth Date: _____ Soc. Sec.: _____ Driver's License: _____

☐ Responsible Party is also Policy Holder ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

PATIENT INFORMATION

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Email: _____ ☐ I would like to receive correspondence via e-mail

SECTION 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Denist: _____ Employer ID: _____

Pref. Pharmacy: _____ Caller ID: _____ Pref. Hyg.: _____

SECTION 3

Cell: _____ Visa: _____ M.C.: _____

FMX: _____ Bridge: _____ Visa Exp.: _____ M.C. Exp: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Insured Soc. Sec.: _____

Employer: _____ Address: _____

Address 2: _____ City/State/Zip: _____

Rem. Benefits: _____.00 Rem. Decut: _____.00

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Birth Date: _____ Ins. Company: _____

Address: _____ Address 2: _____

City, State, Zip: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Insured Soc. Sec.: _____

Employer: _____ Address: _____

Address 2: _____ City/State/Zip: _____

Rem. Benefits: _____.00 Rem. Decut: _____.00

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Birth Date: _____ Ins. Company: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Patient Name: _____

CONSENT

1. I hereby authorize doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with patient. I understand that using anesthetics agents embodies a certain risk.
3. I authorize doctor to choose and employ such assistance as deemed fit to provide recommended treatment.
4. I authorize release of information relating to patient's care to the appropriate insurance carrier or other health care providers.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.

Signature of Patient, Parent or Guardian: _____ Date: _____

AUTHORIZATION TO BILL INSURANCE

1. I authorize doctor to bill my insurance on behalf of patient.
2. I authorize payment of the dental benefits otherwise payable to me directly to the doctor.

Signature of Insured: _____ Date: _____

AGREEMENT TO PAY

1. I understand that all responsibility for payment for dental services provided in this office for patient is due and payable at the time services are rendered unless other arrangements have been made.
2. I understand that, where appropriate, credit bureau reports may be obtained.
3. I understand that in the event patient's insurance coverage is not effective, or any services are not covered, I will be financially responsible for any services rendered.

Signature of Responsible Party: _____ Date: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers for my health services.
- Conduct normal health care operations such as quality assessment and improvement activity.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

FOR OFFICE USE ONLY

We were unable to obtain the patients written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other