DOUG DISRAELI, D.D.S.

# PATIENT REGISTRATION

First Name: _____ Last Name: _____

Address: _____

City: _____ State / Zip: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Ext #_____ CELL #: (_____)_____

Occupation: _____

Employer: _____

Employer Address: _____

Sex ❍ Male ❍ Female Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Widowed ❍ Domestic Partner

Birthdate: _____ Age: _____ Soc. Sec: _____

❒ I would like to receive correspondences via e-mail.

E-mail: _____

Employment Status: ❍ Full Time ❍ Part Time ❍ Retired

Student Status: ❍ Full Time ❍ Part Time If student, where: _____

Responsible Party

First Name: _____ Last Name: _____

Relationship to Patient: _____

Address: _____

City: _____ State / Zip: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Ext #_____ CELL #: (_____)_____

Birthdate: _____ Soc. Sec: _____

Spouse/Significant Other (please use parent's name if under 18) _____

Whom do we contact for emergencies? _____

Phone number of emergency contact (_____) _____

Closest relative not living with you _____

Phone number of closest relative ( _____)_____

Full address of closest relative _____

_____

Whom may we thank for referring you to our office? _____

## DENTAL CARRIER

Subscriber's Name: _____

Subscriber's SSN #: _____

Employer Name: _____

Employer Address: _____

_____

Employer Phone #:(_____) _____

Insurance Carrier Name: _____

Insurance Phone #(_____) _____

Insurance Group #_____

Subscriber DOB: _____

## SECONDARY DENTAL INSURANCE

Subscriber's Name: _____

Subscriber's SSN #: _____

Employer Name: _____

Employer Address: _____

_____

Employer Phone #:(_____) _____

Insurance Carrier Name: _____

Insurance Phone #(_____) _____

Insurance Group #_____

Subscriber DOB: _____

PATIENT NAME _____

I acknowledge that I have received the following:

Initials

(_____) Dental Materials Fact Sheet

(_____) Notice of Privacy Practices

(_____) Informed Consent Forms

I authorize the performance of any laboratory, x-ray or other studies that may be used by Doug Disraeli, D.D.S., or his designated staff as deemed appropriate to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize Doug Disraeli, D.D.S., and his designated staff, to perform all recommended treatment mutually agreed upon by me.

In order to receive treatment, I contract that if there are any differences or disagreements between Doug Disraeli, D.D.S., and myself, I will first present such differences or disagreements to Dr. Disraeli in order to resolve the problem. If we are unable to agree on a solution, then I agree to take the problem to a reconciliation board such as the San Diego County Dental Society's peer review and agree to accept their resolution in lieu of pursuing remedies by way of litigation. In consideration of helping to keep costs of treatment and services as low as possible, I also understand that this agreement is binding on my heirs and all other family members.

I understand and agree that I am fully responsible for payment of all services rendered on my behalf or my dependents, regardless of any insurance coverage that I might provide. I further understand that any balances on my account after 60 days will be assessed a finance charge of 18% APR.

I understand that the contract I have with my dental insurance company is between the insurance company and myself, and does not involve Dr. Disraeli, but if I provide Dr. Disraeli's office staff with complete information relating to my dental insurance, they will assist me by submitting my claims and interceding on my behalf. I authorize Doug Disraeli, D.D.S. and his staff to release information to my insurance company or companies including diagnoses, records of any treatment or examinations rendered. I consent to have payments paid directly to Doug Disraeli, D.D.S. from my insurance company.

$50 missed appointment fee
Remember a broken appointment hurts three people...you, another patient and me. As a result, our office requires 24-hours notice, or you will be charged $50 per hour of appointment time. This means that you must call 24-hours ahead of your appointment time if you wish to cancel, NOT the night before or the morning of your appointment. Please do not wait for us to call and confirm your appointment and then cancel at that time.

_____ _____

Signature (Patient or responsible party) Date