

Patient Registration

www.greatsmilesarehere.com

Dr. Mary Zarekari

(925) 939-9177

Patient Information

Referred By: _____

Name: _____ SS#: _____ Male Female
Last Name First Name

Prefers to be called _____ Birth date _____
MM/DD/YY

Single Married Divorced Widowed Spouse Name: _____

Home Tel: () - _____ Cell Phone: () - _____ Bus. Phone: () - _____

Home Address: _____
Street City State Zip Code

Patient Employed by: _____ Occupation _____ Email: _____

Notify in Case of emergency: _____ Tel: () - _____ Relation to patient _____

Responsible for your account

Name: _____ Birth date _____ Tel: () - _____
Last Name First Name MM/DD/YY

Relation to patient: _____ SS#: _____ Employer: _____

Bus. Address: _____
Street City State Zip Code

Primary Insurance

Insured: _____ Birth date _____ Tel: () - _____
Last Name First Name MM/DD/YY

Relation to patient: _____ SS#: _____ Employer: _____

Bus. Address: _____
Street City State Zip Code

Insurance company name: _____ Group #: _____ Subscriber ID: _____

- I acknowledge that all the above items are correct and accurate
- I hereby authorize **Dr. Mary Zarekari D.M.D.**, her assigned associates, or designated staff to take study models, photographs, and other diagnostic and treatment. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to such assistance as required to provide proper care.
- I agree to use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Print Name

X _____

Signature of Patient
(Parent or guardian if minor)

X _____

Date

Financial Policy

48 hr Cancellation Policy:

There will be a \$50 fee for any missed or broken appointments without 48-hour prior notice. I also understand that the cancellation of scheduled appointment for dental cleaning may result in having to miss a regular three, four, or six-month appointment.

Method of Payment / Financial Policy

- VISA, MasterCard, AMEX, cash, Check (to be verified)
- Financing with Care Credit (upon approval). Up to 12 month no Interest Payment Plan & Extended Payment Plan.
- In the event of returned check an additional amount of \$25 for processing will be charged
- Balances older than 60 days may be subject to collection fees and finance charges at the rate of 18% annually
- All Medical/Dental records and X-Rays are properties of this office and any costs to transfer to another practitioner will incur a duplication fee of \$30. Administration time to return records and other documentation is between 2-4 weeks.

Co-payment / Insurance Coverage

- **Estimated** patient portion is due when services are rendered. We will provide you with an estimate of your portion prior to or during your visit.
- Our office will not enter into a dispute with your insurance company over any claim. Although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.
- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract.

Signature of Patient: (parent or Guardian if minor)

X

Date:

X

HIPPA – Consent Form

Your signature acknowledges receipt of Notice of Privacy Policies and Consent for Disclosure for Treatment, Payment and Operation

By signing below, I hereby acknowledge that I have been provided with copy (take-home copy by request) of this office's Notice of Privacy Practice and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. I hereby consent to the use and disclosure of my health information for treatment purpose, and payment activities. By signing below, I hereby consent to the use and disclosure of my health information for treatment purpose, payment activities.

Signature of Patient: (parent or Guardian if minor)

X

Date

X