NEW PATIENT REGISTRATION
Dr. Amir Sadjadi, D.M.D.

ID: _____ Chart ID: _____

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

Preferred Name: _____ **Today's Date:** _____

Patient is: (circle) Policy Holder Responsible Party

RESPONSIBLE PARTY (if someone other than the patient)

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

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone (with area code) (____) _____ **Cellular:** (____) _____ **Work Phone:** (____) _____

Birth Date (Mo, Day,Year):____/____/____ **Soc. Sec. #** _____ Driver's Lic. #: _____

Responsible Party is also a: (circle) Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

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PATIENT INFORMATION

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

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone (with area code) (____) _____ **Cellular:** (____) _____ **Work Phone:** (____) _____

Sex: (circle) Male Female Marital Status: (circle) Married Single Divorced Separated Widowed

Birth Date (Mo, Day,Year):____/____/____ Age: _____ Soc. Sec. # _____ Driver's Lic. #: _____

EMAIL (please print): _____ O I would like to receive correspondence via e-mail

_____ **Section 2** _____ **Section 3** _____

Employment Status: (circle) Full Time Part Time Retired

Student Status: (circle) Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

ADDITIONAL COMMENTS:

_____

_____

_____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: (circle) Self Spouse Child Other

Insured Soc. Sec. #: _____ Insured Birth Date: (Mo, Day,Year) _____/_____/_____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: $_____.00 Rem. Deductible: $_____.00

SECONDARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: (circle) Self Spouse Child Other

Insured Soc. Sec. #: _____ Insured Birth Date: (Mo, Day,Year) _____/_____/_____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: $_____.00 Rem. Deductible: $_____.00