Quality You Can See *Dr. Scott Sahf & Team*

Patient information

Date of birth _____ Male ☐ Female ☐

Patient name _____
First Initial Last

How do you wish to be addressed _____

Residence address _____

City _____State _____ Zip _____

Home phone # _____Cell#_____

E-mail address _____

Patient Social Security # _____
If child,
Parents name _____
First Initial Last

How did you hear about our office _____

Do you need antibiotics before dental treatment _____

Please circle one: Married Single Widowed Divorced

Someone to notify in case of emergency _____

_____& phone # _____

Employment

Patient/parent employed by _____

Business address _____

City _____State _____ Zip _____

Business phone # _____Ext._____

Present position _____

May we contact you at work? _____

Dental insurance

Employee name _____
First Initial Last

Employee date of birth_____

Employer _____

Patient name _____

Employees Social Security # _____

Name of insurance co. _____

Insurance co. address _____

City _____State _____ Zip _____

Insurance co. phone # _____

Insurance co. fax # _____

Group ID # _____

Please understand that we have no contract with your insurance company but we are happy to file your insurance claims at no charge to you, and help you receive the maximum benefits to which you are entitled; however, we cannot guarantee any **estimated** coverage. **Our contract for services and payment is with you, not the insurance company**. The **estimate** of insurance coverage is not a guarantee of insurance payment, **it is merely an estimate**. In summary, your insurance company may not pay their full **estimated** portion and you agree to be responsible for the total fee regardless of what your insurance pays. After payment has been received from your insurance company, and if they have not paid their **estimated** portion, we will send you a statement asking for the remaining balance. If your insurance company has not paid their **estimated** portion within 90 days from the start of treatment, you are responsible for the remaining balance at that time.

Release:

I authorize the dentist to perform diagnostic procedures and treatment (that has been agreed upon by patient and dentist) as may be necessary for proper dental care.

I authorize the release of any information concerning my (or my child's) health care, advice and treatment to other health care providers and to Dr. Scott Sahf.

I hereby give Dr. Sahf the absolute right and permission to use my audio/visual materials, including photographs/slides for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said materials. I agree that the information on this page is, to the best of my knowledge, accurate and complete and may be used to obtain credit information, if needed.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I hereby authorize payment of insurance benefits directly to Dr. Sahf otherwise payable to me.

LIMITED RELATIONSHIP OF THE EMERGENCY PATIENT

I realize that my relationship with Dr. Sahf is limited to my dental visit today.

I understand that if Dr. Sahf recommends that I am in need of further treatment, it is my responsibility to make and keep that appointment and be sure that I receive further care.

Patient or guardian signature _____ Date _____