

Dr. Amir P. Shaibani
Middlefield Family Dental
15561 West High St., Suite #20
Middlefield, Ohio 44062
Ph(440) 632-0389 Fax(440) 632-9669

PATIENT REGISTRATION

Date: _____ Patient Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

MALE OR FEMALE AGE: _____ MARITAL STATUS: _____

Employment Status: Part Time, Full Time, Retired Patient Social Security # _____

Student Status: Full Time Part Time School Name: _____

RESPONSIBLE PARTY INFORMATION

If patient and responsible party are the same – please proceed to Insurance Info.

Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Relationship To Patient: _____ Social Security # of Responsible Party _____

Employer Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

PRIMARY INSURANCE INFORMATION

Name of Insurance Co.: _____

Insurance Address: _____

City: _____ State: _____ Zip _____

Phone Number: _____ Policy ID# _____ Group #: _____

Policy Holder Name: _____ Date of Birth: _____

Social Security # of Policy Holder: _____ Relationship To Patient: _____

Employer Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Phone Number: _____

Do you have Secondary Insurance? Y or N (circle please)

DENTAL INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Dr. Shaibani – Middlefield Family Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Please Note: Any outstanding balances not paid with in 30 days after billing date will be charged 32% collection fee & legal recovery fee along with interest at 1 ½% per month. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Date: _____
Relationship to Patient: _____

PATIENTS WITHOUT DENTAL INSURANCE

I understand that I am financially responsible for all charges incurred. Please Note: Any outstanding balance not paid with in 30 days after billing date will be charged 32% collection fee & legal recovery fee along with interest at 1 ½% per month.

Responsible Party Signature: _____ Date: _____
Relationship to Patient: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cellular: _____