RAMSIN K. DAVOUD DDS

FAMILY & COSMETIC DENTISTRY

Ramsin k. Davoud DDS. Family & Cosmetic Dentistry
1840 N Olive Ave Ste #2, Turlock, CA 95382
Phone: (209) 690-8051

NEW PATIENT REGISTRATION

ID: _____ **Chart ID:** _____

Patient: Last name: _____ First name: _____ Mid Initial: _____

Preferred Name: _____ Birthday: ____/____/_____ Age: _____

Sex: ☐ Male ☐ Female SSN: _____-_____-_____ Driver's License#: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

Home phone #: (_____) -_____ -_____ Cell #: (_____) -_____ -_____ Work #: (_____) - _____ -_____ Ext: _____

Email: _____ ☐ *I would like to receive correspondences via e-mail.*

Section 02 -

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 03 -

Emergancy Contact: _____ Phone #: (_____) - _____ - _____

RESPONSIBLE PARTY

Patient Is: ☐ **Policy Holder** ☐ **Other Responsible Party** *(If Someone other than the Patient)*

His/ Her Last name: _____ First name: _____ Mid Initial: _____

Birthday: ____/____/_____ SSN: _____-_____-_____ Driver's License#: _____

Home address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

Home phone #: (_____) -_____ -_____ Cell #: (_____) -_____ -_____ Work #:(_____) -_____- _____ Ext: _____

Responsible Party is: ☐ Also a Policy Holder for Patient. ☐ Primary Insurance Policy Holder. ☐ Secondary Insurance Policy Holder.

INSURANCE INFORMATION

Primary Insurance

Insured's Name: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

If Other: _____

Birthday: ____/____/_____ SSN: _____-____-_____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Ins. Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Rem. Benefits: _____.00

Rem. Deduct: _____.00

Secondary Insurance

Insured's Name: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

If Other: _____

Birthday: ____/____/_____ SSN: _____-____-_____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Ins. Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Rem. Benefits: _____.00

Rem. Deduct: _____.00

Patient / Parent (if minor) Signature: _____ Date: _____