WELCOME Samir N. Hanania, DMD, P.A. d/b/a Mandarin Dental Professionals

PATIENT INFORMATION

Last Name: _____ First: _____ M.I._____ Prefers to Be Called By: _____

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

Home Phone: (_____)_____ Cell: (_____)_____ Work: (_____)_____

Birth Date: _____/_____/_____ Age: _____ □ Male □ Female □ Single □ Married □ Divorced □ Widowed

Social Security #: _____ E-mail Address: _____

Occupation: _____ School Attending: _____

Is another member of your family a patient at our office? _____ Relationship: _____

Whom may we thank for referring you? _____

Person to Contact for Emergency: _____ Phone #: (_____)_____

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

Closest Relative Not Living with you: _____ Phone #: (_____)_____

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

ACCOUNT INFORMATION – PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship: _____ Social Security #:_____

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

Phone: _____

DENTAL INSURANCE – PRIMARY CARRIER

Insurance Company: _____ Group #: _____

Employer Name: _____ Insured's Name: _____

Date of Birth: _____ Relationship to Patient: _____ Insured's I.D.#: _____

Insured's Social Security#: _____

CONSENT FOR TREATMENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (**NAME OF PATIENT**) _____'s dental needs.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the 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 complications.
4. **MISSED APPOINTMENTS/LATE CANCELLATIONS**
   We value your time and we expect that you will value the time of Mandarin Dental Professionals. If you need to change or cancel your appointment, please contact us **48 hours prior** to your appointment. I understand that **more than one** "No Show" will result in a $50.00 fee. **Initials** _____
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that collections may become involved. If required, I also understand a check of my credit history may be made**.** In the event Samir N. Hanania, DMD, PA d/b/a Mandarin Dental Professionals retains an attorney to collect any amount owed, I agree to pay all costs and attorney's fees incurred regardless of whether a lawsuit is filed or not. My obligation to pay costs and attorney's fees includes amounts for determining the entitlement to and the amount of such costs and attoney's fees.

Patient's Signature: _____ Date: _____ Witness: _____

Parent/Responsible Party's Signature: _____ Relationship to Patient: _____