GJ Smiles

Carl A. Feghali DDS, PC

REGISTRATION

WELCOME TO OUR OFFICE

The benefits of a happy, healthy smile are immeasurable. Our mission is to help you reach and maintain excellent oral health. Please fill out this form completely to allow us to serve you better.

1. CONFIDENTIAL PATIENT INFORMATION

Name ..... (First,Middle Initial, Last) ☐ M ☐ F Birth Date ..... SS # .....

Home Phone ..... Cell. Phone ..... **E-mail** .....

Residence Address ..... (City, State, Zip)

Mailing Address ..... (City, State, Zip)

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient or Parent / Guardian's Employer ..... (First,Middle Initial, Last) Work Phone .....

Occupation ..... No. of Years Employed .....

Spouse's Name ..... (First,Middle Initial, Last) Birth Date ..... SS # .....

Employer ..... Work Phone ..... Occupation ..... No. of Years Employed .....

Whom may we thank for referring you to our office? .....

2. CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Name of Person Responsible for this Account ..... (First,Middle Initial, Last) Relationship to Patient .....

Address ..... (City, State, Zip) Home Phone ..... Cell. Phone .....

How long at this address ..... Landlord ..... Phone .....

Previous Address - If less than 3 years ..... (City, State, Zip)

Birth Date ..... SS # ..... Driver's License # .....

Employer ..... Work Phone .....

Is this person currently a patient in our office? ☐ Yes ☐ No

3. INSURANCE INFORMATION

Policy Holder's Name ..... (First,Middle Initial, Last) SS # .....

Insurance Company ..... Group # ..... Local Union # .....

Birth Date ..... Policy Holder's Employer .....

Do you have dual insurance coverage? ☐ Yes ☐ No If yes, please answer the following questions:

Policy Holder's Name ..... (First,Middle Initial, Last) SS # .....

Insurance Company ..... Group # ..... Local Union # .....

Birth Date ..... Policy Holder's Employer .....

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4. EMERGENCY INFORMATION

- Name of nearest relative not living with you .....
  (First,Middle Initial, Last)

  Relationship to Patient ..... Home Phone ..... Cell. Phone .....

  Address .....
  (City, State, Zip)

- Name of nearest relative not living with you .....
  (First,Middle Initial, Last)

  Relationship to Patient ..... Home Phone ..... Cell. Phone .....

- I authorize the dental staff to perform any necessary dental services I may need for diagnosis and treatment, the release to my insurance carrier any medical information requested, and request that payment of authorized insurance benefits be made on my behalf to Carl A. Feghali DDS, PC.

- I understand that responsibility for payment of Dental Services provided in this office for myself or my dependents is mine whether Insurance coverage is available or not, due and payable at the time services are rendered, unless financial arrangements have been made. I understand that where appropriate, credit bureau reports may be obtained. In the event of default (I/We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

- I hereby instruct and direct my Insurance Company to pay **Carl A. Feghali DDS, PC** or, if my current policy prohibits direct payment to doctor, please make out the check to us and mail it to **1120 Wellington Ave Suite 203 - Grand Junction, CO 81501** for the professional or dental expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

- A photocopy of this Assignment shall be considered as effective and valid as the original.

- I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

- I authorize the Doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

- Patient authorizes the Doctor to deposit checks received on Patient's account when made out to the Patient.

Date

Signature of Client or Responsible Party