AA

Afsoun Asgharzadeh, DDS

2021 Santa Monica Blvd, Suite 704-E, Santa Monica, CA 90404
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New Patient Registration

Welcome! Please complete every section that applies to you. Type directly into this form on your computer, or print it and fill it out by hand.

Patient information

Last name | First name | Middle initial

Preferred name | Date of birth (MM/DD/YYYY) | Sex / gender

Street address | Apt / suite

City | State | ZIP code

Cell phone | Home or work phone | Email

Best way to reach you

☐ Cell phone call ☐ Text message ☐ Email ☐ Home or work phone

Occupation | Employer

Primary care physician | Physician phone

Emergency contact

Emergency contact name | Relationship to patient | Emergency contact phone

Responsible party

Person responsible for the account, if not the patient

☐ Same as patient (skip this section)

Responsible party name | Relationship to patient | Responsible party date of birth

Responsible party address (if different) | Responsible party phone

Responsible party email | Responsible party employer

Primary dental insurance (PPO)

Please bring your insurance card to your visit

Primary insurance company | Primary insurance phone | Primary employer / plan sponsor

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New Patient Registration

continued

Primary subscriber name

Primary subscriber date of birth

Primary relationship to patient

Primary subscriber / member ID

Primary group number

Secondary dental insurance (PPO)

Leave blank if none

Secondary insurance company

Secondary insurance phone

Secondary employer / plan sponsor

Secondary subscriber name

Secondary subscriber date of birth

Secondary relationship to patient

Secondary subscriber / member ID

Secondary group number

How did you hear about us?

- ☐ Google search or Maps
- ☐ Zocdoc
- ☐ Yelp
- ☐ Insurance directory
- ☐ Friend or family
- ☐ Another doctor or dentist
- ☐ Social media
- ☐ Walked or drove by
- ☐ Other

Referred by (name), or other source

Authorization

I confirm that the information on this form is accurate to the best of my knowledge. I authorize Afsoun Asgharzadeh, DDS to release information needed to process my dental insurance claims, and I authorize payment of insurance benefits directly to the practice. I understand I am responsible for any balance not paid by insurance.

Patient (or parent/guardian) signature (type your name, or sign on paper)

Date (MM/DD/YYYY)