Welcome To The General, Cosmetic, & Implant Dentistry Practice Of Mohamed Ali, DDS

To help us process your insurance correctly, please fill out this form completely and notify us of any change.
We will be happy to help if assistance is required.

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: ____ Mr./Mrs./Ms./Dr.

Preferred Name: _____ ☐ Male ☐ Female Date of Birth: ____/____/____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Cell #: _____ Home #: _____ Work #: _____ Email: _____

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

Minor: Yes/No Name of School: _____ Full-time Student: Yes/No

RESPONSIBLE PARTY INFORMATION

First Name: _____ Last Name: _____ Date of Birth: ____/____/____

Social Security #: _____ Relationship to Patient: _____

Cell #: _____ Home #: _____ Work #: _____ Email: _____

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

Name of Employer: _____ Occupation: _____

Dental Insurance Company: _____ Dental Insurance Ph #: _____ Health Insurance Company: _____ Health Insurance Ph #: _____

ADDITIONAL INSURANCE INFORMATION

First Name: _____ Last Name: _____ Date of Birth: ____/____/____

Social Security #: _____ Relationship to Patient: _____

Cell #: _____ Home #: _____ Work #: _____ Email: _____

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

Name of Employer: _____ Occupation: _____

Dental Insurance Company: _____ Dental Insurance Ph #: _____ Health Insurance Company: _____ Health Insurance Ph #: _____

WHO CAN WE THANK?

Referred by Friend: _____ Other (Please Specify): _____

AGREEMENT TO PAY

I understand that I am responsible for payment of services rendered and for paying any co-payment and deductible that my insurance does not cover. I hereby authorize payment directly to Mohamed Ali, DDS. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Patient Signature: _____ **Date:** _____