

**Welcome to Dr. Parisa Sepehri's office!**

Thank you for choosing our office for your dental needs.  
We strive to make each visit pleasant and comfortable.

**Patient Information:**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ M / F  
Last First MI

Minor \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_ Other \_\_\_\_\_

If minor - Who is responsible for this account? \_\_\_\_\_ Relationship \_\_\_\_\_

**Responsible Party Information**

SS#: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ DL#: \_\_\_\_\_ State \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ OK to call at work? Y / N

Person to contact in case of Emergency? : \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Insurance Information:**

**Primary Insurance:**

Name of Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_ Group #: \_\_\_\_\_ ID#: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Phone#: \_\_\_\_\_

**Secondary Insurance:**

Name of Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_ Group #: \_\_\_\_\_ ID#: \_\_\_\_\_

**Financial Arrangements:**

Payment is expected at each appointment. For your convenience we offer the following methods of payment: Visa/MC/AX \_\_\_\_\_ Personal Check \_\_\_\_\_ Cash \_\_\_\_\_ Care Credit \_\_\_\_\_

Signature of Responsible person: \_\_\_\_\_ Date: \_\_\_\_\_