RAMOUNA KARVAR, D.M.D.

COSMETIC, IMPLANT AND FAMILY DENTISTRY
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DENTAL REGISTRATION

Patient Name: _____ Date of Birth: _____

Nickname: _____ Sex: M F Marital Status: _____

Address: _____
Street Number City State Zip code

E-mail Address: _____

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

Social Security #: _____ Referred By: _____

Would you prefer to be contacted at (circle one): Home Cell phone E-mail Work

Would you prefer to receive statements (circle one): Mail E-mail

PREFERRED PHARMACY: _____ PHONE #: _____
**If you have Kaiser Permanente, please provide your Medical Record #: _____

PRIMARY DENTAL INSURANCE

Subscriber Name: _____ Date of Birth: _____

Relationship to patient: _____ Name of Insurance: _____

Insurance ID#: _____ (or social security number if different from above)

SECONDARY DENTAL INSURANCE

Subscriber Name: _____ Date of Birth: _____

Relationship to Patient: _____ Name of Insurance: _____

Insurance ID#: _____

EMERGENCY CONTACT

Name: _____ Relation: _____ Phone Number: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Karvar all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Ramouna Karvar DMD may use my health care information and may disclose such information to the above-named Insurance Company and their representatives for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature: _____ Date: _____