AZIM PRESSWALA DDS LLC
REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle: ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Birth date: Age:

❑ M ❑ F

Street address: Social Security no.: Home phone no.: ( )

P.O. box: City: State: ZIP Code:

Email : Cell no:

Preferred Pharmacy:

Referred to clinic by

Other family members seen here:

Circle one: Medicaid Private Ins Cash Pay

INSURANCE INFORMATION

ID # NAME

Is this person a patient here? ❑ Yes ❑ No

Occupation: Employer:

PRIVATE INSURANCE NAME :--

Subscriber's name/address: Subscriber's S.S. no.: Birth date: / / Group no.: Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

SECONDARY INSURANCE INFORMATION Subscriber's name: Group no.: Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: ( ) Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize AZIM PRESSWALA DDS LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*