WELCOME TO OUR OFFICE

DR NISRINE CABANI DMD,LLC **Today's Date _____**
Located in the Publix Plaza at Kings Ridge
4371 S. Hwy 27 Suite C-15
Clermont FL 34711
(352) 243-6808

Thank you for choosing our office.
In order to serve you properly our office requires the following information. (PLEASE PRINT) All information is **STRICTLY confidential**.

Patients Name_____Date of Birth_____Marital Status
- □ **Single**
- □ **Married**
- □ **Widowed**
- □ **Divorced**

Address_____

City_____State_____Zip_____

Home Telephone_____Cell Phone_____

E-Mail_____

Patient Social Security # _____Driver License #_____
(If minor use parent or guardian) or State ID

If Minor, Parent or Guardian Name_____

Do you have Dental Insurance? **If a payment is due how will you settle your account?**

□ **Yes** **Cash Check Credit Card**
□ **No** **(Circle One)**

Dental Insurance Company Name_____

Name of Ins Subscriber_____DOB:_____ SSN or Ins ID#_____

Name of Employer _____Work #_____ Ext:_____

Employer Address_____

Person Financially Responsible for your account._____ Relationship to Patient_____

Person to call in event of emergency_____ Phone Number_____

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage.

Patient, Parent, or Guardian Signature_____Date Signed_____