HAZIM DENTAL CLINIC P.C.
Ziad A. Hazim DDS
12661 SE Powell Blvd, Ste E ▪ Portland, OR 97236 ▪ Tel. (503) 761-1120 ▪ www.hazimdental.com

PATIENT INFORMATION

Patient

Full Name:				Date:	
	Last	*First*	*Middle*		
Address:					
	Street Address			*Apartment/Unit #*	
	City	*State*		*ZIP*	
Phone:	( ) -		Cell:	( ) -	
E-mail:			Work:	( ) -	
SSN:	- -	DOB:		Age:	
Employer:			Phone:	( ) -	
Emergency Contact:			Phone:	( ) -	

Responsible Party *if same as above, please skip*

Full Name:				Date:	
	Last	*First*	*Middle*		
Address:					
	Street Address			*Apartment/Unit #*	
	City	*State*		*ZIP*	
Phone:	( ) -		Cell:	( ) -	
E-mail:			Work:	( ) -	
SSN:	- -	DOB:		Age:	

Insurance / Dental Plan

Primary: ☐ Insurance ☐ PPO ☐ HMO				**Secondary:** ☐ Insurance ☐ PPO ☐ HMO			
Insurance Name:				Insurance Name:			
Insurance Phone:	( ) -			Insurance Phone:	( ) -		
Employer:				Employer:			
Group #		Plan #		Group #		Plan #	
Subscriber's Name:				Subscriber's Name:			
Subscriber's SSN:		DOB:		Subscriber's SSN:		DOB:	

How did you hear about us?

☐ Family/Friend ☐ Newspaper ☐ Office Sign ☐ Insurance Plan ☐ Yellow Pages ☐ Internet/Website

Patient Signature

I certify that the information provided above is accurate in providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for any reason. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims. I understand that this dental practice is owned and operated by an independent dentist.

Signature of Responsible Party or Patient:		Date:	