Paul Gayed DMD || 2551 N. Clark Street, Suite 500, Chicago, Illinois 60614 || 773-549-2881

Patient Registration

Name ______________________________ Home Phone ______________
Address ______________________________ Cell Phone______________
City ______________________________ State ____________ Zip __________
Email ______________________________ Social Security Number ______________
Date of Birth ______/______/________ Gender/Identify as ____________________
Whom may we thank for referring you? ______________________________

Person to contact for Emergency ______________________ Phone ____________________
Address ____
Street City State Zip Code

Closest Relative Not Living with you ______________________ Phone ________________
Address ____
Street City State Zip Code

Your Occupation ______________________________ Employer__________
Employer's Address Address ______________________________________
Street City State Zip Code

Name of Spouse/Partner ______________________________________
Spouse/Partner Occupation______________________________ Employer __________
Spouse/Partner Phone ______________________________________

Do you have Dental Insurance *Yes or No* (If you have provided us with it you may skip this section)
If Yes, Who is the subscriber? ______________________________________
(if the subscriber is yourself, fill in the spaces you **did not** fill above)
Subscriber's Date of Birth? ___/_____/______Subscriber's Social Security Number__________
Dental Insurance Company ___________________
Group Name ______________________________
Group Number ____________________________
Dental Insurance Address

____
Street City State Zip Code

Consent:

The undersigned hereby Authorizes Paul Gayed DMD to take X-rays, study model, photos; or any other diagnostic aids deemed appropriate by. Dr. Paul Gayed to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Paul Gayed to perform any and all forms of treatment, medication and therapy, that may be indicated and further authorize any consent that Dr. Gayed choose and employ such assistance as he deems fit, I also understand the use of anesthetic agents embodies a certain risk, I understand that responsibility for payments for Dental services provided in this office for myself or my dependents is mine, due and payable at the time of services are rendered unless financial arrangements have been made. I further understand that a 10% finance charge will be added to any balance over 60 days. In the event of default, I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. This office policy reserves the right to charge a $ 75.00 fee for any canceled or broken appointment without 24 hours notice.

Patient Signature ______________________________ Date_____________
Parent Or Responsible Party ______________________________ Date _____________
Witness ______________________________ Date _____________