

**WELCOME TO THE PRACTICE OF DR. DIMITRI GANIM
REGISTRATION FORM**

NAME _____ DOB _____ Male ___ Female

Home Address _____

City/State/Zip _____

Phones: Home _____ Cell _____ Work _____ ext. _____

E-Mail Address _____ What would you like us to call you? _____

Employer _____ Occupation _____

Other family members in this practice _____

Person responsible for account (if not patient) _____ Relationship _____

Address _____ Phone _____

Employer _____ Occupation _____

PRIMARY DENTAL INSURANCE INFORMATION:

Policy Holder _____ DOB _____ Employer _____

Insurance Co. _____ Group No. _____ ID# _____

SECONDARY DENTAL INSURANCE INFORMATION:

Policy Holder _____ DOB _____ Employer _____

Insurance Co. _____ Group No. _____ ID# _____

Person to notify in case of emergency (someone not living with you):

Name _____ Relationship _____ Phone _____

Whom may we thank for referring you to our practice? _____

I authorize Dr. Dimitri G. Ganim to perform dental diagnostic procedures and treatment necessary for proper dental care. I consent to the release of any information that may be necessary to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I authorize payment of all insurance benefits directly to Dr. Ganim and the use of this signature for all insurance submissions. I understand I am financially responsible for payment of all charges, regardless of insurance coverage. In the event of delinquency, I'll incur 1.5% monthly interest on the unpaid balance, as well as all collection fees.

I understand that payment is due as dental treatment is performed unless other arrangements have been made prior to treatment. A fee may be charged for appointments cancelled with less than 24 hours weekday notice.

I have reviewed/received a copy of this office's Notice of Privacy Practices.

I certify all information on the front and back of this form is complete and accurate.

Signature of Responsible Party _____ Date _____