Dr. Hooman Shakiba, DMD
East Vancouver Dentistry
Patient Registration

How did you hear about our office? _____

First Name: _____ Last Name: _____ MI: _____
Pref Name: _____
Address: _____ City, State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Sex: M / F Marital Status: ___Married ___Single ___Divorced ___Separated ___Widowed
Birth Date: _____ Social Security Number: _____ Drivers Lic: _____
Email: _____
Employment: ___Full Time ___Part Time ___Retired ___Unemployed
Employer: _____ Phone: _____
Address: _____
Preferred Pharmacy: _____ Phone #: _____
Is Patient the Responsible Party? Yes / No

Is there anything that you would change about your smile or that you are concerned with?
Missing teeth Crooked teeth Color Other _____

Responsible Party: (If patient is responsible party, you do not have to fill out this section)
First Name: _____ Last Name: _____ MI: _____
Address: _____ City, State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Sex: M / F Marital Status: ___Married ___Single ___Divorced ___Separated ___Widowed
Birth Date: _____ Social Security Number: _____ Drivers Lic: _____
Is responsible part policy holder for the patient? Yes / No

Primary Insurance Information:
Insured Name: _____ Birth Date: _____ SS#: _____
Relationship to patient: _____ Member ID: (if different than SS#): _____
Insurance Company Name: _____ Group #: _____
Ins Address: _____ City, State: _____ Zip: _____
Employer: _____ Phone: _____

Secondary Insurance Information:
Insured Name: _____ Birth Date: _____ SS#: _____
Relationship to patient: _____ Member ID: (if different than SS#): _____
Insurance Company Name: _____ Group #: _____
Ins Address: _____ City, State: _____ Zip: _____
Employer: _____ Phone: _____