HFD
HAMMOUD
FAMILY DENTAL

Omran Hammoud, D.D.S.
5777 West Maple Rd., Suite 160, West Bloomfield, MI 48322
248-851-2980

PATIENT REGISTRATION

Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Birth Date: _____ Email address: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single

Occupation: _____

Please check **2 ways** that you would like your appointments confirmed:
☐ Home ☐ Cell ☐ Text ☐ Email

Financial Information

Person responsible for payment: _____

Relationship to patient: _____

Social Security #: _____ Driver's License #: _____

Credit Card #: _____ Expiration Date: _____

Dental Insurance Information

Name of Insured: _____ Birthdate: _____

Relationship to patient: _____ Employer: _____

Insurance Company Name: _____ Insurance phone number: _____

Insurance ID #: _____ Group #: _____

AUTHORIZATION

I hereby authorize payment directly to the dental office the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third-party payer and/or other health professionals.

Signature: _____

☐ Adult Patient ☐ Parent/Guardian