Patient Information

Arthur Kezian D.D.S.

With over twenty-five years' experience in Dentistry, **Dr. Kezian** is uniquely qualified to restore smiles in as conservative and as painless a way possible. He is dedicated to restoring his patients to an optimal degree of dental health using the latest technological advances.

Kindly assist us in getting to know you better by filling out the following forms to the best of your knowledge. Thank you and welcome to our practice.

Patient Information:

Patient's Name (Last)_____(MI)_____(First)_____
Address:_____Apt._____City_____State_____Zip_____
Social Security Number_____DOB:___/___/___
Employer_____Occupation_____
Business Address:_____Suite____City___State___Zip_____
Home Phone Number: (___)_____Business Number: (___)_____
Cell: (___)_____
E-Mail Address:_____
Source of Referral:_____
Reason for today's visit:_____

Emergency Contact Information:

Name: (Last)_____(MI)_____(First)_____
Daytime Number: (___)_____Evening Number: (___)_____
Address: _____Apt.____City_____State_____Zip_____
Relationship:_____

Responsible Party's Information: (Only to be completed if the patient is under 18)

Responsible Party's Name (Last)_____(MI)____(First)_____
Address:_____Apt._____City_____State_____Zip_____
Social Security Number_____DOB___/____/_____
Employer_____Occupation_____
Business Address_____Suite_____City_____State_____Zip_____
Home Phone Number: (____)_____Business Number: (___)_____
Cell: (___)_____
E-Mail Address_____

Arthur Kezian D.D.S. / Narine Tashjian D.D.S.
443 Norht Larchmount Blvd, Los Angeles, California 90004
Telephone: 323.467.2777 / email: kezian@msn.com / website: www.drkezian.com

Insurance Information

Arthur Kezian D.D.S.

To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare all necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the patient.

If you have dental benefits and would like us to assist you in receiving disbursement from them, kindly provide us with the following information:

Insured Member's Information

Name(Last)_____(MI)___(First)_____DOB___/___/___

Address_____Apt._____City_____State_____Zip_____

Employer_____Occupation_____Bus. Num._____

Please Circle: Social Security # or Member ID#_____

Group/Policy#_____

Insurance Company's Information

Insurance Company Name_____

Insurance Company Phone Number_____

Dental Claim Mailing Address_____

Signature_____
(Parent or Guardian, if patient is a minor)

Date_____

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