Mayers & Nakisbendi
Dental Associates

Michael P. Mayers, DMD • Leyla Z. Nakisbendi,DMD

Patient's Name_____ **Date of Birth** _____

Address_____

_____

Cell Phone_____ **Home phone**_____

Insured Name_____ **Insured Date of Birth**_____

Insured Address (if different than above) _____

_____

Social Security # insured_____ **Insurance Telephone #**_____

Insurance Company _____ **Group #**_____

Policy #_____ **Member ID#**_____

We do appointment confirmations electronically through a program called Lighthouse.

Would you prefer to receive appointment reminders through T E X T E-MAIL BOTH

Whom may we thank for your referral?_____.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I acknowledge that I have received Dr. Mayers and Nakisbendi's notice of Privacy Practices, according to the HIPPA guidelines.

Signature _____ Date _____

(08/09/2016)