Alamo Springs Dental Patient Registration Form

We know that you have many choices when it comes to selecting your dentist. Thank you for giving us the opportunity to provide you and your family with our dental services. Welcome!

Patient Name: Last:_____ First:_____ MI:_____

Street Address_____ City_____ State_____ Zip_____

Cell Phone:_____ Home Phone:_____ Work Phone _____

Employer:_____ Email:_____

Date of Birth:_____ Social Security#:_____

If student, name of school:_____ **Pharmacy Name & Phone**:_____

Emergency Contact:_____ Relationship_____ Phone:_____

How did you hear about us? Please circle/list: Postcard, Drive By, Friend, Family, Internet, Other:_____

Responsible Party

If the patient listed above IS NOT responsible for payment on this account, please complete the following:

Person Responsible for Account: Last name_____ First:_____ MI:___

Social Security # of Responsible Party:_____

Address:_____City_____ State:_____ Zip_____

Employer_____ Work Phone:_____

Spouse's Name:_____ Spouse's Employer_____

1. It is **OK** to be contacted about appointments and leave messages in regards to treatment via (***CIRCLE ALL THAT APPLY***):

HOME PHONE **CELL PHONE** **FAX** **TEXT MESSAGE** **EMAIL**

2. I **allow** you to give my clinical information to or answer questions from (***check all that apply***):

☐ Spouse ☐Parent ☐Child ☐Other (specify)_____ ☐No One

I, _____, hereby acknowledge that I have received/read a copy of Alamo Springs Dental's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice. (See the Privacy Notice laminated pages at the end of patient forms or framed at the front desk.)

_____ _____

Name Date

I verify that the information is correct. For insurance claims, I authorize the release of any information relating to this claim and the use of photostatic copy of the treatment plan for the services rendered. I authorize payment to Alamo Springs Dental for the insurance benefits otherwise payable to me. I also agree to be responsible for any balance occurring on this account, including any amounts not covered by any dental insurance (insurance pre-determinations are estimates only), pre-payment, capitation or other dental programs. ***Please give our office a 24 hrs notice if unable to make your scheduled appointment to avoid the $75.00 cancellation fee.***

_____ _____

Signature **Date**