

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 \$50 cancellation fee.***

Signature

Date