JOSE J. ALVAREZ, D.M.D. & ASSOCIATES

REGISTRATION FORM

PLEASE PRINT CLEARLY

Your feedback is very important. Please tell us how you heard about us so we can give proper thanks!

☐ Internet ☐ Clipper Magazine ☐ Social Media ☐ Insurance ☐Other: _____

☐ Friend (***please provide name***): _____

PATIENT NAME_____ **DATE**_____
(LAST) (FIRST) (MIDDLE)

PATIENT'S DATE OF BIRTH: _____/_____/_____ **PATIENT'S AGE:** _____

SOCIAL SECURITY NUMBER: _____ **EMAIL:**_____

ADDRESS: _____
(STREET) (APT) (CITY) (STATE) (ZIP CODE)

HOME# _____ **WORK#** _____

CELL# _____ **OTHER#** _____

***IF MINOR*, PARENT/GUARDIAN'S NAME / RESPONSIBLE PARTY**_____

EMERGENCY CONTACT _____ **PHONE#** _____

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FINANCIAL AGREEMENT

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES OF SERVICES PERFORMED ON ME, INLCUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE.

_____ _____
SIGNATURE OF PATIENT ***(OR GUARDIAN IF PATIENT IS A MINOR)*** **DATE**

FOR PATIENTS WITH INSURANCE

I AUTHORIZE RELEASE OF ANY INFORMATION RELATED TO CLAIMS FOR THE ABOVE-LISTED PERSON AND AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER OF SERVICE, OTHERWISE PAYABLE TO ME.

_____ _____
SIGNATURE OF PATIENT ***(OR GUARDIAN IF PATIENT IS A MINOR)*** **DATE**

_____**INITIALS -APPOINTMENTS:** Once an appointment is made, please remember that time has been reserved for you. A charge may be assessed for dialed or cancelled appointments without 24 hour notification. This fee covers only a portion of the overhead whether you are present or not**.**

_____**INITIALS -NOTE:** After patient's third broken appointment without 24 hour prior notice to our office, the patient will no longer be seen in the office.

_____**INITIALS - INSURANCE:** To avoid any misunderstandings regarding your dental insurance, we wish to let the patient know that all professional services rendered will be billed to your insurance as a courtesy to you. We will assist in all necessary claim submission to obtain payment for your dental services within 60 days. If payment from your insurance carrier has not been received after 60 days, balance will be charged directly to you.

_____**INITIALS – ACCOUNT** Any fees or co-payment are expected and due at the time of services are rendered. Any unpaid account over 90 days will be turned over to a collection agency. Patient will be responsible for any and/or all legal fees**.**