RALPH W ALMAN, JR, DDS, PA

Dental Implants ✦ Oral Maxillofacial Surgery

PATIENT REGISTRATION FORM

Patient Information: DATE: ____________

Last Name: ____ Title (Dr, Rev, etc.): ____________

First Name: ________________________ Middle Initial: ______ Date of Birth: __________ Age: ________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed   Sex: ☐ Male ☐ Female

Email Address: ____   Please check the best number to reach you.

Street Address: ____   Mobile ☐mom ☐dad #:☐ ______________

City: ____   Work ☐mom ☐dad #:☐ ______________

State: ☐ MD ☐ DC ☐VA Other: _____ Zip/Code: __________   Home #:☐ ______________

Employment: ☐ Employed ☐ Retired ☐ Self-Employed   Other #: ________________ :☐ ______________

Occupation: ______________________________ Employer: ________________________________

If Student, School Attending: ________________________________

Have you ever been a patient of Dr. Alman? ☐ Yes ☐ No

Has anyone in your family been a patient of Dr. Alman? ☐ Yes ☐ No ________________________________

Referral Information: Who referred to our office? ☐ Dentist ☐ Family ☐ Friend ☐ Other

Name of General/Restorative Dentist: ____

And/Or Dental Specialist: ☐ Prosthodontist ☐ Endodontist ☐ Orthodontist ☐ Pediodontist ☐ Periodontist

Name of Dental Specialist: ____

Referred by Friend/Family/Other: ____

Dental Insurance & Payment: ☐No Dental Insurance   Dental Policy Holder: ☐ Self ☐ Spouse ☐ Parent

Most oral surgery procedures are covered by dental insurance. Occasionally, we are able to submit to your medical insurance. Please discuss this with the staff before providing medical insurance information.

Please show your insurance card to assist assuring that the correct information is submitted:

Policy Holder Name: ________________________ Date of Birth: __________ ID #: ____________________

Policy Holder Address: ☐ Same ____

DENTAL Insurance Name: ______________________________

DENTAL Insurance Address: ____

As an additional service, we are pleased to file to your dental insurance for you to be reimbursed.

☐ I acknowledge that Dr. Alman does not participate with any insurance plans as a preferred provider.

☐ I authorize the release of information (X-rays & contacting my referring dentist) as necessary.

Today's Fees Will Be Paid By: ☐ Cash ☐ Check ☐ Credit Card (VISA, MC, or Discover - We do not accept AMEX)

Privacy & Patient Acknowledgements:

☐ I acknowledge that I have been given the right to review the Notice of Privacy Practices for this office (HIPAA).

☐ I have read and understand this entire form. I affirm that the information contained in this form and any additional information that I may furnish is true and correct to the best of my knowledge. I understand that this information is necessary to provide dental care in a safe and efficient manner. I will not hold Ralph W Alman, Jr, DDS, PA or the staff responsible for any errors or omissions that I have made in the completion of this form.

☐ I understand that I am responsible for all costs of this treatment, including all collection fees, interest of 1½% from the original date of treatment, attorney fees, & court fees. Returned checks are subject to a $50 fee.

____ __________

Signature (☐ Patient ☐ Parent ☐ Legal Guardian ☐ Medical Surrogate)   Date: