ALAMO
Family & Cosmetic
DENTISTRY Pllc

Patient Information

Prefix: _____
Last Name: _____ First Name: _____ Middle: _____

Nickname: _____ Suffix :_____SSN: _____Date Of Birth:_____

Patient Address: _____

City:_____ State: _____ Zip Code: _____
Occupation: _____ Sex : Male ☐ Female ☐ Marital Status: Single ☐ Married ☐ Divorced ☐
Race:☐ White☐ Black/ African American ☐ Asian American ☐ Indian/Alaska Native ☐ Hispanic☐ Non-Hispanic☐ Unknown

Emergency Contact: _____ Phone Number: _____ Relationship: _____

Spouse Full Name : _____ Phone Number: _____

Patient Home #: _____ Patient Work #: _____ Patient Mobile #: _____

Preferred Contact #: ☐ Mobile ☐ Home ☐ Work Is it OK to leave a detailed message: ☐ Yes ☐ No

Email Address: _____

How did you hear about office:☐ Insurance Website ☐ Internet/Google ☐ Friend x_____☐ Postcard☐ Other

Guarantor Information / Responsible Party

Guarantor Contact Information: ☐ Same as Patient

Patients Relationship to Guarantor (please circle): ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Guarantor Last Name: _____ Guarantor First Name: _____

Guarantor SSN: _____Guarantor Date Of Birth:_____ Phone #:_____

Patient Address: _____
City:_____ State: _____ Zip Code: _____

Consent for Release of Medical Information to Family Members or Representative
☐ Yes, The Practice May Discuss: ☐ Medical Condition/ Treatment ☐Appointments ☐Prescriptions ☐Financial with:

I understand this authorization may include information related to Dental/Medical History and Treatment
Initial: _____
Please list Authorized Person (s) Below:
Name:_____ Relationship: _____ Phone Number: _____
Name:_____ Relationship: _____ Phone Number: _____

Patient Printed Name_____ Patient Signature_____ Date :_____

Guarantor Printed Name_____ Guarantor Signature_____ Date :_____

Alamo Family & Cosmetic Dentistry, PLLC
8131 IH-10 West, Suite 217
San Antonio, TX 78230

Patient Medical History

Patient Name:_____
Date of Last Dental Visit:_____ Reason for this visit:_____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies_____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Pressure
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Stroke
- ☐ Venereal Disease
- ☐ Sleep Apnea
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due Date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Tuberculosis
- ☐ Codeine Allergy
- ☐ Other
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Tumors
- ☐ Ulcers
- ☐ Penicillin Allergy

OTHER:_____
List of medications:_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐Yes ☐No
  If yes, please explain:_____

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____

- Name of Physician:_____ Phone:_____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X_____ _____

Signature of patient, parent or guardian Date

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Welcome To Our Practice

We are excited to welcome you as a new patient. We would like to get to know you a little, please take a few minutes to provide us with the answers to the following questions:

1. The primary reason for my visit today is to discuss: _____

_____

2. I would like to know more regarding the following procedures:

Teeth Whitening	Yes	No	
Veneers and Cosmetic Dentistry	Yes	No	
Dental Implants	Yes	No	
Snoring Reduction	Yes	No	
Braces	Yes	No	
Replacing Silver Fillings	Yes	No	
Replace Missing Teeth	Yes	No	
Sleep Apnea	Yes	No	Date Diagnosis_____

Please use the space below to indicate any other problems, concerns, or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best possible treatment options. Thank you.

Patient Signature x _____ Date:_____

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****** Please read and initial to provide consent& acknowledgment and sign at bottom. ******

Patient Acknowledgement

X_____	PATIENT RESPONSIBILITY . I understand that I am financially responsible for all services rendered. I understand that my insurance coverage is a contract between myself and my insurance company. Therefore, I am financially responsible for any unpaid balance not covered by my insurance. All copays, deductibles, and coinsurances not covered by my insurance carrier are my responsibility and will be due at the time of service.
X_____	PAYMENT ASSIGNMENT. I authorize and assign directly to Alamo Family & Cosmetic Dentistry, Pllc, all insurance benefits, if any, payable for any services rendered otherwise payable to me. I understand that this office will prepare all necessary claim forms to reasonably assist me in making collection from the insurance company.
X_____	INFORMATION RELEASE. I authorize, Alamo Family & Cosmetic Dentistry, Pllc to release all protected health information to my insurance carrier (s) (including Medicare, if appropriate) and third-party collection agencies in order to secure payment for services rendered. I also authorize Alamo Family & Cosmetic Dentistry, Pllc to release my medical information to my Primary Care Provider or Referring Provider for continuity of my care if applicable.
X_____	TREATMENT GUARANTEE. While optimal results are anticipated from providers , I understand that there can be no guarantee or warranty, expressed or implied by anyone as to the actual results I may get , especially in cosmetic services . I also understand that additional charges, in which I will be responsible , will be applied for the management of problems and / or complications.
X_____	GENERAL CONSENT. I consent to treatment rendered from the provider(s) and his/her directed support staff at Alamo Family & Cosmetic Dentistry, Pllc
X_____	MEDICATION CONSENT. I consent for Alamo Family & Cosmetic Dentistry, Pllc to access and obtain a history of my medications purchased at pharmacies. I acknowledge it is my responsibility to inform provider of all medications being taken at each visit.
X_____	APPOINTMENT NO-SHOWS: Any patient who fails to arrive for a scheduled appointment without cancelling the appointment at least 24 hours prior to the schedule time is considered a “no-show”. A no-show patient may be charged $50.00 , as set by the Practice, for failure to show. A patient who is no-show three times may be dismissed from the Practice.

Patient Printed Name_____ Patient Signature_____ Date :_____

Guarantor Printed Name_____ Guarantor Signature_____ Date :_____

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DENTISTRY Pllc

We would like to thank you for choosing Alamo Family & Cosmetic Dentistry as your dental provider. We are committed to providing you with the best possible dental care. We are sure you understand that payment for this dental care is your responsibility.

The following information outlines your financial responsibilities related to payment for professional services.

For Our Patients with Dental Insurance Benefits:

We participate in most major health plans. We have contracts with many PPO, EPO insurance companies and government agencies including Medicare. Our billing office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance, we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If your insurance requires a preauthorization or referral it is your responsibility to obtain those. Please bring your insurance card(s) with you at the time of your appointment. If you are insured by a plan, we do business with but don't have an insurance card with you, payment in full for each visit is required until we can verify your coverage.

Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payment may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. If you are unable to pay your copayment your appointment may be rescheduled. Additionally, you may have coinsurance and /or deductible amounts required by your insurance carrier. These amounts are due at the time of service. Any outstanding balance on your account, after adjusting for all of your insurance's responsibilities, we be billed to you.

For Our Patients with No Dental Insurance Benefits:

If you do not have group or individual dental insurance, payment for all professional services is expected at the time of your visit.

Cosmetic Services:

Payment for all cosmetic services is due at the time of service. We will not take partial payment for cosmetic services unless it it approved by a provider and management.

Late Arrivals :

A patient who arrives more than 15 minutes after his/her appointment is considered a late arrival. A late arrival, not considered to be the responsibility of the Practice, will be registered and worked into the schedule if possible or patient may need to have appointment rescheduled.

Divorced Parents of Patients:

By signing below, the adult who checks a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who checks in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

Delinquent Balance:

Patients with a delinquent balance are required to make payment in full at times service . A delinquent account is defined as a patient balance in excess of 90 days where the patient has not made any payments or sought assistance via financial hardship during this time. If such payment is not made, services may be refused . I agree to pay any costs incurred by Alamo Family & Cosmetic Dentistry, Pllc in collecting any amount due including , without limitations collection agency fees ,the maximum interest rate allowed by State or Federal law and attorneys fees.

Signature : _____ Date : _____