



# Dental Solutions Riad Almasri, D.D.S.

3102 Oak Lawn Ave, Suite 204  
Dallas, TX 75219  
214-521-5900

## PATIENT REGISTRATION

### Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Responsible Party (if someone other than the patient) \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed  Partnered  Other

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_ I would like to receive correspondences via e-mail  Yes  No

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Employed By: \_\_\_\_\_ Spouse/Partner Employed By: \_\_\_\_\_

### Insurance Information

Insured Name: \_\_\_\_\_ Relationship to Patient:  Self  Spouse/Partner  Parent

If insured is other than patient: Insured Birthdate: \_\_\_\_\_ Insured Social Security Number or ID #: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Group Number: \_\_\_\_\_

Carrier Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Carrier Phone: \_\_\_\_\_

### Release:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my health care, advice and treatment to another dentist.

I understand that Dental Solutions is **not** a contracted provider with my insurance carrier. My dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of **all** accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date