Austin Hills Dental

Patient Information:

Name: ____ Date of Birth: _____________

Address: ____

____

Home: _________________________ Cell: ____________________ Work: __________________

Email: ____

Pharmacy: _________________________________ Ph: _________________________________

How were you referred to our office? ____

If you have an emergency after hours, please call our number 512-263-3330 and it will prompt you to reach the dentist.

Emergency Contact:

Name: ____ Relationship: ______________

Ph: _________________________

Insurance Information:

Carrier: ____________________________ Address: ____________________________________

Ph: _______________________ Subscriber's Name: _____________________________________

Patient's relationship to subscriber: __________________ Subscriber's DOB: _______________

SS#: __________________________________ ID# _____________________________________

Group/Plan #: ___________________________________

Acknowledgement of Financial Policy and Consent

Payment is due at the time of service unless prior arrangements have been made. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will assist in completing the necessary insurance forms for claim submission. However, we cannot render services on the assumption that our charges will be paid by an insurance company.

I consent to the making of videos/photographs/x-rays before, during, and after treatment to be used by the doctor in scientific papers or demonstrations.

I certify I have read and understand this notice.

Signature: ____________________________________ Date: _____________________________