ALAA MOUSTAFA, DDS, MS
Board Certified Prosthodontist

Patient Information Form

Patient Name: First _____ Last _____Nickname_____

Date of Birth: _____ **__Male __ Female**

Cell Phone: _____**Home Phone:** _____

E-mail address:_____

Address: Street _____

City _____State _____ Zip _____

Is the patient a Minor? _____Yes _____ No

Name of guardian: First _____ Last_____

Relationship to Patient : _____

How would you like us to confirm your appointment? ____Text ____Email _____Phone

How did you hear about our office?_____

_____ **Rescheduling an Appointment:** We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. To maintain the utmost service and care, **we do require 24-hour notice to reschedule an appointment.**

_____**Unencrypted email** is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication.

_____I hereby acknowledge that a copy of this practice's **Notice of Privacy Practices** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____I hereby acknowledge that a copy of this practice's **Dental Materials Fact Sheet** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet.

Signature _____ Date _____