LAKESIDE DENTAL
FAMILY & COSMETIC DENTISTRY

PATIENT REGISTRATION FORM

I. PATIENT INFORMATION

TODAY'S DATE: _____ OFFICE USE ONLY: ☐ New Patient ☐ Existing Patient Verified Gov't Issued ID: ☐ Yes ☐ No

PATIENT NAME: _____ PATIENT'S DATE OF BIRTH: _____
Last Name First Name Middle Initial

HOME ADDRESS: _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

CITY: _____ STATE: _____ ZIP: _____ ☐ Separated ☐ Divorced ☐ Partnered for ___ years

PATIENT'S PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Other _____

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT: _____ RESPONSIBLE PARTY'S DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____

HOW DID YOU FIND US? ☐ Google Search ☐ Google Maps ☐ Friend ☐ Family ☐ Existing Patient ☐ Insurance Website ☐ Physician/Specialist Referral
☐ Drive By ☐ Social Media ☐ Other _____

IF APPLICABLE, WHOM CAN WE THANK FOR REFERRING YOU? _____

II. CONTACT INFORMATION

HOME PHONE: _____ CELL PHONE: _____ E-MAIL: _____

WORK PHONE: _____ EXTENSION: _____ SPOUSE/PARENT CELL: _____

PREFERRED METHOD OF CONTACT: ☐ Text ☐ E-mail ☐ Phone

May we send text messages regarding treatment and billing? ☐ Yes ☐ No
May we send e-mails regarding treatment and billing? ☐ Yes ☐ No
May we leave detailed voicemails regarding treatment and billing? ☐ Yes ☐ No

EMERGENCY CONTACT: _____ LIVES WITH PATIENT: ☐ Yes ☐ No

RELATIONSHIP TO PATIENT: _____

HOME PHONE: _____ CELL PHONE: _____ WORK: PHONE: _____

III. DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

DOES PATIENT HAVE DENTAL INSURANCE? ☐ YES ☐ NO

PATIENT'S SOCIAL SECURITY NUMBER: _____

POLICY HOLDER'S NAME: _____

RELATIONSHIP TO PATIENT: _____

POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____

INSURANCE COMPANY _____

ID# _____ PHONE: _____

SECONDARY INSURANCE

IS PATIENT COVERED BY SECONDARY INSURANCE? ☐ YES ☐ NO

POLICY HOLDER'S NAME: _____

RELATIONSHIP TO PATIENT: _____

POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____

INSURANCE COMPANY _____

ID# _____ PHONE: _____

I certify that the information provided is accurate and complete to the best of my knowledge.
I understand it is my responsibility to notify Lakeside Dental of changes to my contact information, insurance coverage, or personal information.

PATIENT OR PARENT/GUARDIAN SIGNATURE: _____ DATE: _____