

# LAKE SIDE DENTAL

FAMILY & COSMETIC DENTISTRY

# PATIENT REGISTRATION FORM

## I. PATIENT INFORMATION

TODAY'S DATE: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DRIVER'S LICENSE # AND STATE: \_\_\_\_\_  
Last Name First Name Middle Initial

HOME ADDRESS: \_\_\_\_\_  Married  Widowed  Single  Minor

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  Separated  Divorced  Partnered for \_\_\_ years

SEX AT BIRTH:  Male  Female AGE: \_\_\_\_\_ PATIENT'S DATE OF BIRTH: \_\_\_\_\_

PATIENT EMPLOYED BY: \_\_\_\_\_ PATIENT OCCUPATION: \_\_\_\_\_

BUSINESS ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PERSON RESPONSIBLE FOR THIS ACCOUNT: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

SPOUSE/PARENT (please circle which) NAME: \_\_\_\_\_ SPOUSE/PARENT DATE OF BIRTH: \_\_\_\_\_

SPOUSE/PARENT Employed by: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

BUSINESS ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOW DID YOU FIND US?  Word of Mouth  Referred by Specialist  Internet Search  Insurance Company

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 CONTACT METHOD:  HOME PHONE  CELL PHONE  WORK PHONE  TEXT  E-MAIL OPT OUT OF TEXT COMMUNICATIONS:  YES

OPT OUT OF E-MAIL COMMUNICATIONS:  YES

EMERGENCY CONTACT (Specify someone who does not live in your household) \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ WORK: PHONE: \_\_\_\_\_

## III. DENTAL INSURANCE INFORMATION

### PRIMARY INSURANCE

DOES PATIENT HAVE DENTAL INSURANCE?  YES  NO

SUBSCRIBER'S NAME: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SSN: \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_

ID# \_\_\_\_\_ PHONE: \_\_\_\_\_

NAMES OF OTHER PEOPLE COVERED UNDER THIS PLAN \_\_\_\_\_

### SECONDARY INSURANCE

IS PATIENT COVERED BY SECONDARY INSURANCE?  YES  NO

SUBSCRIBER'S NAME: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SSN: \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_

ID# \_\_\_\_\_ PHONE: \_\_\_\_\_

NAMES OF OTHER PEOPLE COVERED UNDER THIS PLAN \_\_\_\_\_

The information contained on this form is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health or insurance.

Patient or Parent/Guardian's Signature: \_\_\_\_\_ DATE: \_\_\_\_\_