LAKESIDE DENTAL

REGISTRATION FORM

Please Print

Today's date _____

PATIENT INFORMATION

Patient's Last Name: _____ First: _____ Middle: _____

Home Phone #: _____ Work #: _____ Cell #: _____ Email Address: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Martial Status: Single ☐ Mar ☐ Sep ☐ Widow ☐ Gender: Male ☐ Female ☐ Birth Date: _____ Age: _____

Occupation: _____ Employer: _____ Social Security No: _____

Person Responsible for Account: _____ Address: _____ Home Phone #: _____

Birthdate: _____ Social Security #: _____ Drivers License #: _____ Cell Phone #: _____

REFERRED BY: ☐ Phone Book ☐ Location ☐ Patient (Name): _____ ☐ Other: _____

Person to Contact for Emergency: _____ Phone No: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Is This Patient Covered By Insurance? ☐ Yes ☐ No Do You Have Medicaid? ☐ Yes ☐ No

Name of Primary Insurance: _____ Group No: _____ Policy No: _____

Subscriber's Name: _____ Subscriber's SS No: _____ Birthdate: _____

Patient's Relationship To Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary Insurance (if applicable) Subscriber's Name: _____ Group No: _____ Policy No: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

CONSENT

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the above named patient. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless financial arrangements have been made. I authorize my insurance benefits to be paid directly to the dental office. I also authorize the dental office or insurance company to release any information required for this claim. I understand that I am responsible for any fees not paid by insurance and that a credit report may be obtained if necessary. I also understand that a $50 - $100 fee will be charged for missed appointments, and that this charge is not covered by insurance or any other state program as per WAC 388-535-1265(ff) and WAC 388-535-1100(s). I understand that if I need to change an appointment time, a 24-hour notification is necessary to avoid this fee. It is also clear to me that no further appointments can be scheduled until this fee has been paid. Additional charges may be incurred in the case of multiple missed appointments.

Signature _____ Relationship to Patient _____ Date _____

Patient, Parent or Guardian