LAKESIDE FAMILY DENTISTRY, LLC
PATIENT REGISTRATION

First Name:_________________________ Last Name:_________________________ Middle Initial:______
Patient Is: ____ Policy Holder Preferred Name:____________________________
____ Responsible Party

PATIENT INFORMATION:

Address:____
City: ________________________________ State/Zip:______________________Cell Ph:_______________
Home Phone:_________________________ Work Phone:_____________________________Ext: _________
E-mail:____Preferred Method of contact is: ____________
Sex: ____M ____F Birth Date:________ Marital Status: ___Married ___Single ___Divorced ___Separated
Employer:____________________________ Address:____
I was referred by: Family/Friend_____________________________ Yellow Pages_____ Web Site _____

RESPONSIBLE PARTY (if someone other than the patient):

First Name:________________________ Last Name:____________________________ Middle Initial:______
Address:____
City, State, Zip:____Cell Ph:_______________
Home Phone:________________________ Work Phone:_____________________________Ext:___________
Birth Date:__________________ Soc Sec #______________________ Drivers License:__________________
Employer:___________________________ Address:____
____Responsible Party is also a Policy Holder for Patient :____Primary Ins Holder ____Secondary Ins Holder

PRIMARY DENTAL INSURANCE INFORMATION:

Name of Insured:________________________________Relationship to Insured:____Self___Spouse____Child
Isnured Soc. Sec:___________________________ Insured Birth Date: ______________________
Employer:__________________________________Address:____
Insurance Company____
Address:____
Insurance Phone_______________________________ Policy#______________________ Grp #_____________

SECONDARY DENTAL INSURANCE INFORMATION:

Name of Insured:________________________________Relationship to Insured:____Self___Spouse____Child
Isnured Soc. Sec:___________________________ Insured Birth Date: ______________________
Employer:__________________________________Address:____
Insurance Company____
Address:____
Insurance Phone_______________________________ Policy#______________________ Grp #_____________