

**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  
Insured 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  
Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Address: \_\_\_\_\_  
Insurance Phone \_\_\_\_\_ Policy# \_\_\_\_\_ Grp # \_\_\_\_\_