PATIENT REGISTRATION

FIRST NAME ______________________ LAST NAME ______________________ MIDDLE INITIAL __________

BIRTHDATE ______________ AGE ______ MALE ______ FEMALE ______ REFERRED BY ______________________

ADDRESS ______________________________ CITY ______________ STATE ______ ZIPCODE ____________

HOME PHONE ______________ WORK PHONE ______________ EXT ________ CELL ______________

EMAIL ______________________ MINOR ______ SINGLE ______ MARRIED ______ SEPARATED ______ WIDOWED ______

EMPLOYER ______________________ POSITION ______________________ SOC SEC ______________

SPOUSE'S FULL NAME ______________________ BIRTHDATE ______________ CELL ______________

SPOUSE EMPLOYER ______________________ POSITION ______________ WORK PHONE ______________

NAME OF EMERGENCY CONTACT: (Nearest relative, not living with you) ______________________ PHONE ______________

MINOR INFORMATION

FATHER'S FULL NAME ______________________ BIRTHDATE __________ CELL ______________ SOC SEC ______________

FATHER'S EMPLOYER ______________________ POSITION ______________ WORK PHONE ______________ EXT __________

MOTHER'S FULL NAME ______________________ BIRTHDATE __________ CELL ______________ SOC SEC ______________

MOTHER'S EMPLOYER ______________________ POSITION ______________ WORK PHONE ______________ EXT __________

PRIMARY DENTAL INSURANCE

NAME OF SUBSCRIBER ______________________________ BIRTH DATE ______________ SOC SEC ______________

INS. COMPANY ______________ ADDRESS ______________ CITY ______________ STATE ______ ZIP _______

ID # ______________________ GROUP # ______________ MAXIMUM BENEFIT PER YEAR __________ DEDUCTIBLE __________

RELATIONSHIP TO SUBSCRIBER: SELF ______ SPOUSE ______ CHILD ______ OTHER ______

SECONDARY DENTAL INSURANCE

NAME OF SUBSCRIBER ______________________________ BIRTH DATE ______________ SOC SEC ______________

INS. COMPANY ______________ ADDRESS ______________ CITY ______________ STATE ______ ZIP _______

ID # ______________________ GROUP # ______________ MAXIMUM BENEFIT PER YEAR __________ DEDUCTIBLE __________

RELATIONSHIP TO SUBSCRIBER: SELF ______ SPOUSE ______ CHILD ______ OTHER ______

AUTHORIZATION PLEASE READ CAREGULLY AND SIGN

I hereby authorize release of information necessary to file a claim with my insurance company and authorize payment directly to Lake Dental Care of insurance benefits otherwise payable to me. I understand that my dental insurance company may pay less than the actual bill for services. I understand that I am financially responsible for payment in full of all accounts.

I understand that a finance charge of 1.5% per month (18% per year) will be charged on my balance over 90 days.

I hereby authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care.

SIGNATURE OF RESPONSIBLE PARTY ______________________________________ DATE ______________________

(PARENT OR GUARDIAN IF PATIENT IS A MINOR)