New Patient information, Insurance and Signature of Assignment. Please fill out completely.

PATIENT INFORMATION

NAME Last: First: MI: DOB:		
ADDRESS:		SSN#:
CITY: ST:	ZIP:	SPOUSE'S NAME:
HOME PHONE#:	Marital Status ___Single___Married___Divorced___Widowed	
CELL PHONE#:	E-MAIL:	
Driver's License #:	Male_____ Female_____ Transgender_____ Other_____	
Name on Insurance Card (if different than above):		Previous Dentist:

PATIENT EMPLOYMENT INFORMATION

_____Employed _____Retired _____Unemployed _____Student

EMPLOYER INFORMATION	*EMERGENCY CONTACT*
Employer:	Name:
Phone:	Phone:
Occupation:	Relationship to patient:

PRIMARY DENTAL INSURANCE	*SECONDARY DENTAL INSURANCE*
Name of Subscriber:	Name of Subscriber:
Self_____Parent_____Spouse_____Guardian_____	Self_____Parent_____Spouse_____Guardian_____
Subscriber's Date of Birth:	Subscriber's Date of Birth:
Subscriber's SSN#:	Subscriber's SSN#:
Subscriber's Employer:	Subscriber's Employer:
Insurance Company:	Insurance Company:
ID#:	ID#:
Group#:	Group#:
Phone #:	Phone #:

PERSON RESPONSIBLE FOR ACCOUNT Self____Parent____Guardian____ Other____

NAME:		DATE OF BIRTH:	
SSN#:		PHONE:	
Address:	City:	ST:	ZIP:
Employer:	Phone:		

Whom may we thank for referring you to our office?

I understand payment for dental services provided is due and payable at the time services are rendered unless prior financial arrangements have been made. I understand that Lakeside Dentistry will bill my insurance as a courtesy, and 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 my insurance company. We do require 24 hour advance notice for cancellation, if not, there may be a $30 fee charged to your account.

Signature of Patient/Legal Guardian:

Print Name: DATE: