LAKEVILLE FAMILY DENTAL CENTRE

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Patient Registration

Patient First Name: _____ Last Name _____

Today's Date: _____ Patient Birthdate _____

Patient is: ☐ Policy Holder ☐ Responsible Party ☐ Child ☐ Other _____

How did you hear about us: _____

Responsible Party:

First Name: _____ Last Name: _____ Middle Initial _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: ☐ Male ☐ Female E-mail: _____

Birth Date: _____ Social Security# _____ DL# _____

Name of person to contact in an emergency: _____ Phone# _____

Primary Insurance Information: Group# _____ ID# _____

Name of Insured: _____ Relationship to Patient: _____

Insured Soc. Sec. # _____ Insured Birth Date: _____

Employer: _____ Insurance Company _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information: Group# _____ ID# _____

Name of Insured: _____ Relationship to Patient: _____

Insured Soc. Sec. # _____ Insured Birth Date: _____

Employer: _____ Insurance Company _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____