New Patient Registration

PATIENT INFORMATION

Patient : last name : _____ first name : _____ mid name : _____

Your birthday: ____/____/_____ Age: _____ Sex: ☐ Male ☐ Female

Home address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

Home phone #: (_____) - _____ - _____ Cell Phone #: (_____) - _____ - _____ Work Phone #: (_____) - _____ - _____ Ext: _____

Email address: _____

Employer: _____

Emergency Contact :_____ Phone #: (_____) - _____ - _____

INSURANCE INFORMATION

Primary insurance

Dental Insurance Co.: _____

Group/ Policy # :_____

Insured's name: _____

Insured's Birthday: ____/____/_____ SSN:_____-____-_____

Relationship: _____

Employer: _____

Secondary insurance

Dental Insurance Co.: _____

Group/ Policy #:_____

Insured's name: _____

Insured's Birthday: ____/____/_____ SSN: _____-____-_____

Relationship: _____

Employer: _____

TO OUR PATIENTS

We accept cash, checks, Visa, Mastercard, American Express and Discover. Financial arrangements must be made prior to and in advance of any treatment. Emergency services are due and payable at the time of service. South Lakewood Dental will not render any dental services on the assumption that the charges will be paid by an insurance company.

If you participate in a dental insurance plan, we will prepare your claim form and provide information requested by your insurance company.

FOR YOUR PROTECTION, PLEASE REVIEW YOUR POLICY AND KNOW YOUR BENEFITS. If you need additional information with respect to your insurance coverage, we suggest you refer to your insurance company directly as that information is not available to us.

AUTHORIZATION FOR TREATMENT

☐ I _____, understand that I am responsible for all costs of my dental treatment. I authorize South Lakewood Dental to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper and prudent dental care. The information on this page and the dental/medical histories is correct to the best of my knowledge. I understand that during my appointmnet(s) this dental office may take photographs, x-rays, videos and/or models that may be shared with other dental professionals for the purpose of treatment, communication, training and/or education. I grant the dentist permission to release information about my dental/medical histories and my treatment to other health professionals as it relates to my care. All information will otherwise be held in the strictest of confidence.

Signature: _____ Date: _____