PATIENT REGISTRATION

Patient' Name:

Address: | E-Mail Address

City, State: | Zip Code:

Home Phone: | Work Phone: | Cell Phone:

Birthdate: | Social Security #: | Marital Status:

Employer: | Occupation: | Business Phone:

Spouse's Name: | Birthdate: | Social Security #:

Occupation: | Business Phone #:

PERSON FINANCIALLY RESPONSIBLE:

Name: | Relationship to Patient:

Address:

City, State: | Zip Code: | Telephone Number:

DENTAL INSURANCE:

Company Name: | Group Number:

Name on Policy: | ID#:

Is another member of your family or relative a patient in our office? | Relationship:

Emergency Contact: | Telephone Number:

WHOM MAY WE THANK FOR REFERRING YOU?

1.) I hereby authorize Lakeview Family Dentistry to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a through diagnosis.

2.) Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3.) I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Patients Signature: | Date: | Or Responsible Party: | Relationship: