PATIENT REGISTRATION

PATIENT INFORMATION

First Name:_____ Last:_____ MI:_____

E-mail:_____

Address:_____ Apt.:_____

Street:_____

City:_____ State/Zip:_____

Mobile Phone:_____ Work Phone:_____ Home Phone:_____

Employer Name: _____ Work Address: _____

_____

Birth Date:_____ Soc. Sec. or Insurance ID: _____

Permission granted to Lakeside Dental to share and discuss dental care, diagnostic information, treatment recommendations, financial responsibility and dental insurance benefits with the following individuals:

_____

_____

_____

Signature: _____

Print Name: _____

Date:_____

I agree to be responsible for all charges for dental service and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted by law. I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Lakeside Dental.

X_____

PATIENT/GUARDIAN SIGNATURE DATE

	Yes	No
Consent for dental care at Lakeside Dental.	○	○
Consent for communication including leaving messages by phone or email.	○	○
I have reviewed office privacy practices. Copy available by request.	○	○

X_____

PATIENT/GUARDIAN SIGNATURE DATE