Lakewood Dental Group

Registration Form

Name (First, MI, Last)_____Date:_____
Address_____
City_____ State_____ Zip_____
Home Phone #_____ Cell Phone #_____
Email address_____
May we call you during the day? Yes / No Where? _____Date of birth_____
Social security #_____ Driver's License # _____
Marital Status: Single / Married / Widowed / Divorced
Employer_____ Phone #_____
Person responsible for account_____
Person to notify in an emergency_____ Phone #_____

Please answer:
May we give information regarding your treatment or discuss billing issues with anyone other than you: Yes / No If so, who:_____
May we leave a message on voicemail regarding treatment / billing? Yes/ No

How did you hear about our office?
☐ Online ☐ Good Location ☐ Insurance Co.
☐ Referred by one of our patients. His or her name: _____
☐ Other: Please specify_____

I hereby authorize the doctor to perform any forms of treatment, medication, and therapy, which may be deemed necessary. I also understand that before treatment, the doctor and/or staff will give full explanation of the procedure(s) involved. I agree to pay for services rendered by this dental practice.

Signed (patient or parent if minor)_____ Date:_____

I authorize the use of any radiographs and/or photographs for use in seminars or publications of Lakewood Dental Group.

Signed (patient or parent if minor)_____ Date:_____

Dental Insurance Information
Insured is: ☐ Self ☐ Husband ☐ Wife ☐ Mother ☐ Father

Employee's name_____ Employee's SSN _____Employee's DOB_____
Employer_____ Employer telephone #_____

Second Insurance Carrier Information (If Any)
Employee's name_____ Employee SSN_____. Employee's DOB_____
Employer_____ Employer telephone #_____

I understand that as a service to me, Lakewood Dental Group will assist me in processing my insurance claims. However, I understand that I am completely responsible for all fees.

Signed (patient or parent if minor)_____ Date:_____