LAKEWOOD RANCH FAMILY & COSMETIC DENTISTRY

www.LakewoodRanchSmiles.com

PATIENT REGISTRATION

*PLEASE PRESENT PHOTO I.D. & **DENTAL** INSURANCE CARD TO FRONT DESK*

PATIENT INFORMATION:

First name: _____ Last name: _____ MI: _____

Preferred name: _____

Address: _____ City, State, Zip: _____

Home phone: _____ Work phone: _____ Cell: _____

Marital status: Married __ Single __ Divorced __ Widowed __

Birth date: _____ SSN: _____ Sex: Male __ Female __

Emergency contact: Name: _____ Phone: _____

Preferred pharmacy: Name: _____ Location: _____

RESPONSIBLE PARTY INFORMATION (if someone other than patient):

First name: _____ Last name: _____ MI: _____

Address: _____ City, State, Zip: _____

Home phone: _____ Work phone: _____ Cell: _____

Birth date: _____ SSN: _____

Relationship to pt: Spouse __ Parent __ Other __

DENTAL INSURANCE INFORMATION:

Name of Insured: _____

Relationship to Insured: Self __ Spouse __ Child __ Other __

Insured's SSN: _____ Insured's D.O.B.: _____

Name of Insurance Co.: _____

Employer: _____

- **Payment is required at time of service.**