LAKEVILLE ADVANCED DENTAL CARE

PATIENT REGISTRATION

Patient Information

Name: _________________________________ (_____________) Social Security #: _______________
Last Name First Name Preferred Name

Address: _________________________________ ____________________ _______ ________
Street City State Zip

Home Phone: _________________ Cell Phone: __________________ Email: _____________________

Sex: Male ____ Female ____ Birthdate: _____________ Age: ______

Single: ____ Married: ____ Widowed: ____ Separated: ____ Divorced: ____

Employer: _________________________________ Occupation: ______________________________

Work Address: ______________________________ ___________________ _______ ________
Street City State Zip

Work Phone: ______________________

Emergency Contact: ________________________________ Phone: _________________________

How did you hear about us or who may we thank for referring you? _____________________________

Primary Dental Insurance

Policy Holder: ___________________________________ ______________ ___________________
Last Name First Name Date of Birth Relationship to Patient

Address (if different from patient): ______________________ ______________ ______ _________
Street City State Zip

Policy Holder's Employer: ________________________________ Occupation: __________________

Business Address: __________________________ ___________________ _______ ________
Street City State Zip

Business Phone: ____________________

Insurance Company: _________________________ SS or ID#: ________________ Group #: ________

Additional family members under this plan: ____

Does Patient have Secondary Dental Insurance? ☐ Yes ☐ No

I certify that the above information is true and correct to the best of my knowledge.
I agree to notify Lakeville Advanced Dental Care of any changes in the above information and/or my health status.

____ ___________________________
Signature of Patient, Parent or Guardian Date