Lakeside
FAMILY DENTAL CARE

Welcome to Lakeside Family Dental Care!

PATIENT INFORMATION

Patient's Name_____ Date of Birth_____

Address_____ Home Phone #_____

City _____Zip_____ Cell Phone # _____

Occupation_____ Driver License#_____

Spouse's Name_____ Social Security # _____

How did you hear about our office? _____

Dental Benefits _____ Policy #_____

Employer_____ Work #_____

Physician's Name_____ Last Seen_____

Emergency Contact _____ Phone # _____

RESPONSIBLE PARTY INFORMATION

(IF POLICY HOLDER IS DIFFERENT THAN ABOVE PLEASE FILL OUT)

Dental Benefits_____ Policy # _____

Employer_____ Work Phone #_____

Name _____ Social Security # _____

Relationship to patient_____ Date of Birth _____

Home Phone #_____Cell Phone #_____ Driver License # _____

RESPONSIBILTY AND CONSENT STATEMENT

I hereby authorize and request the performance of dental services for myself or for _____ Age :_____

I understand and agree that (regardless of my dental benefits status), I am ultimately responsible for the balance on my account for any professional services rendered at the time the services are performed. Furthermore, it is my understanding that if any portion of my balance remains unpaid over 60 days, a late charge of 1.5% will be assessed monthly against the outstanding balance of my account. If my account remains unpaid, I will also be responsible for any and all collection costs and reasonable attorney's fees incurred to collect debit. There will be a charge of $34.00 for returned checks plus any bank service charges. I understand that it is my responsibility to honor my reserved appointment time that I have committed to on your schedule. I am aware that if I am unable to make that committed appointment, then I must give a 24 hour notice or I will be charged a $32.00 broken appointment fee. I have read and understand all the information and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in health status or the above information.

_____ _____ _____

(Signature of responsible party) Date (Relationship to named)

We appreciate your confidence in us.
We strive to provide our patients with the highest quality dental care using the most advanced technology.

THANK YOU FOR CHOOSING LAKESIDE FAMILY DENTAL CARE! LFD-004