



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 # _____

RESPONSIBILITY 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 \$31.00 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 \$30.00 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!