

PATIENT REGISTRATION

LAKESHORE FAMILY DENTISTRY, PA

DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

(Last) (First) (MI)

Single Married Separated Widowed Divorced

RESIDENCE ADDRESS: _____
(Street) (City) (State) (Zip)

TELEPHONE: Home: _____ Business: _____

PATIENT'S SOCIAL SECURITY # _____ EMPLOYER NAME: _____

PRESENT POSITION: _____

SPOUSE'S NAME: _____ SPOUSE'S EMPLOYER: _____

NAME OF PERSON REFERRED BY: _____

IF FULL TIME STUDENT, LIST SCHOOL: _____

BILLING INSTRUCTION

NAME OF PERSON TO BE BILLED: _____ RELATIONSHIP: _____

ADDRESS (IF DIFFERENT): _____

EMPLOYER: _____ OCCUPATION: _____

BUSINESS PHONE: _____ HOME PHONE: _____

DENTAL INSURANCE COMPANY: _____

SUBSCRIBER'S (EMPLOYEE'S) SOCIAL SECURITY #: _____

INSURANCE GROUP NUMBER: _____

ARE YOU COVERED BY A SECOND DENTAL PLAN? _____ NAME OF PLAN: _____

EMPLOYER: _____ EMPLOYEE'S SOCIAL SECURITY #: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

LAKESHORE FAMILY DENTISTRY, PA, EXPECTS PAYMENT THE DAY SERVICES ARE RENDERED. IF YOU HAVE INSURANCE, WE WILL BE GLAD TO SUBMIT YOUR CLAIM FOR YOU. ALL ACCOUNTS ARE SUBJECT TO A FINANCE CHARGE COMPUTED ON THE UNPAID BALANCE 60 DAYS AND OVER. MAXIMUM PERIODIC RATE AND ANNUAL PERCENTAGE RATE ARE DETERMINED BY THE LAWS OF THE PATIENT'S STATE OF RESIDENCE. IN THE EVENT A FINANCE CHARGE MAY BE MADE ON YOUR ACCOUNT, THE PERIODIC RATE IS 1.5% AND THE ANNUAL PERCENTAGE RATE IS 18%.

FINAL RESPONSIBILITY FOR PAYMENT RESTS WITH THE PERSON TO WHOM THIS STATEMENT IS ADDRESSED.

PATIENT SIGNATURE: _____

(If patient is a minor, parent or guardian signature, please)