



**LAKESIDE DENTAL REGISTRATION**

**PATIENT INFORMATION**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_  
Best phone number to reach you at during business hours\*\*\*  
 E-Mail Address \_\_\_\_\_ Pager \_\_\_\_\_  
 Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
 Patient Employer/School \_\_\_\_\_  
 Patient Occupation/Student Status \_\_\_\_\_  
 Whom may we thank for referring you?\*\*\* \_\_\_\_\_  
 Emergency contact Person & Phone number \_\_\_\_\_  
 Marital Status \_\_\_\_\_ Spouses Name \_\_\_\_\_  
 Physician \_\_\_\_\_ Physicians's Number \_\_\_\_\_

**DENTAL HISTORY**

Date of last dental visit \_\_\_\_\_  
 Date of last dental xrays \_\_\_\_\_  
 How often do you floss \_\_\_\_\_  
 How often do you brush \_\_\_\_\_  
 Have you ever had periodontal treatment \_\_\_\_\_

**DENTAL INSURANCE**

**Primary Dental Insurance Information:**

Who is Responsible for this account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Address \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Employer \_\_\_\_\_  
 Insurance Co./Address/Phone # \_\_\_\_\_  
 \_\_\_\_\_  
 Group Number \_\_\_\_\_ Subscriber I.D./SS# \_\_\_\_\_

**Secondary Dental Insurance Information:**

Who is Responsible for this account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Address \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Employer \_\_\_\_\_  
 Insurance Co./Address/Phone # \_\_\_\_\_  
 \_\_\_\_\_  
 Group Number \_\_\_\_\_ Subscriber I.D./SS# \_\_\_\_\_