LAKELANDSMILE
EXPERTS

REGISTRATION FORM Section I: Patient Information

Date: _____

Name: _____ SSN: _____-____-_____ Date of Birth: _____

Address: _____ _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____Work Phone: (_____) _____ Cell Phone: (_____) _____

☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employer: _____ Work Phone: _____

Whom may we thank for referring you? _____Email:_____

Emergency Contact: _____ Phone: _____

Would you like to receive our e-newsletter? ☐ Yes ☐ No

Section II Responsible Party (if other than you)

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: _____Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Employer: _____ Work Phone (____) _____ SSN#: _____

Section III Insurance Information (if None, skip this section)

Name of Main Insured: _____ DOB: _____

Relationship to Patient: _____

SSN#:_____ Name of Employer: _____ Work Phone: (____) _____

Address of Employer: _____City: _____ State: _____ Zip: _____

Insurance Company: _____ Grp #: _____ ID#: _____

Ins Co Address: _____ Ins Co. Phone: _____

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Section IV Dental History

Reason for today's visit: _____

When was your last cleaning:

_____

Check if you have any problems with the following:

☐ Bleeding Gums ☐ Grinding Teeth ☐ Sores or growths in your mouth
☐ Clicking or popping of jaw ☐ Loose teeth or broken fillings ☐ Broken Teeth

Is there anything about the appearance of your teeth that you are unhappy with or would like to improve?

☐ Yes ☐ NO If yes, please explain: _____

Section VI Medications

List any medications you are currently taking:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Section VI Allergies (If none, Check None)

☐ **None** ☐ Latex ☐ Penicillin
☐ Barbiturates (Sleeping Pills) ☐ Sulfa
☐ Codeine ☐ Metal Allergies
☐ Local Anesthetic
☐ Aspirin

Other_____
_____
_____
_____

Signature

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

Doctor Signature: _____