LAKESIDE ORAL SURGERY
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PATIENT REGISTRATION FORM

PATIENT ACCOUNT NO.	DATE

PATIENT INFORMATION (please write information about the patient here)

PATIENT'S NAME (last, first, middle initial) | EMAIL ADDRESS

PATIENT'S ADDRESS | CITY | STATE | ZIP | TELEPHONE (home) | TELEPHONE (mobile)

SEX: Male Female | MARITAL STATUS: Single Married Seperated Divorced Widowed | PREFERRED METHOD OF CONTACT: Email Home Phone Mobile Phone Text

DATE OF BIRTH | AGE | EMPLOYER | TELEPHONE

SOCIAL SECURITY NUMBER | DRIVERS LICENSE NUMBER | EMPLOYMENT STATUS: Full Part Retired Not Employed | STUDENT STATUS (if 19 years or older): Full Part Not A Student

INSURANCE INFORMATION (please write information about the patient's insurance here)

PRIMARY INSURANCE COMPANY NAME | Medical | Dental | W. Comp.

INSURANCE COMPANY'S ADDRESS | CITY | STATE | ZIP

INSURED'S ID NUMBER | GROUP PLAN NUMBER

SECONDARY INSURANCE COMPANY NAME | Medical | Dental | W. Comp.

INSURANCE COMPANY'S ADDRESS | CITY | STATE | ZIP

INSURED'S ID NUMBER | GROUP PLAN NUMBER

POLICYHOLDER INFORMATION

(complete if PATIENT is NOT the POLICYHOLDER)

Is the secondary policyholder the: Patient Primary Policyholder Other
(complete if you checked "Other")

PRIMARY POLICYHOLDER'S NAME (last, first, middle initial) | TELEPHONE

PRIMARY POLICYHOLDER'S ADDRESS | CITY | STATE | ZIP

SEX: Male Female | DATE OF BIRTH

EMPLOYER'S NAME OR SCHOOL NAME | TELEPHONE

SOCIAL SECURITY NUMBER | RELATIONSHIP TO PATIENT

EMPLOYER PLAN COVERAGE: Yes No | IF CHAMPUS STATUS IS: Active Retired Deceased

SECONDARY POLICYHOLDER'S NAME (last, first, middle initial) | TELEPHONE

SECONDARY POLICYHOLDER'S ADDRESS | CITY | STATE | ZIP

SEX: Male Female | DATE OF BIRTH

EMPLOYER'S NAME OR SCHOOL NAME | TELEPHONE

SOCIAL SECURITY NUMBER | RELATIONSHIP TO PATIENT

EMPLOYER PLAN COVERAGE: Yes No | IF CHAMPUS STATUS IS: Active Retired Deceased

RESPONSIBLE PARTY INFORMATION

Responsible party is: Patient Primary Policyholder Secondary Policyholder
(complete if the person responsible for paying the bill is NOT the PATIENT or the POLICYHOLDER)

RESPONSIBLE PARTY'S NAME (last, first, middle initial) | TELEPHONE | SOCIAL SECURITY NO. | DRIVERS LICENSE NO. | DATE OF BIRTH

RESPONSIBLE PARTY'S ADDRESS | CITY | STATE | ZIP | EMPLOYER'S NAME | TELEPHONE

SEX: Male Female | RELATIONSHIP TO PATIENT | EMPLOYER'S ADDRESS | CITY | STATE | ZIP

I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES SHOWN ON THE PAGE 2 OF THIS FORM. YOU SHOULD READ THOSE TERMS CAREFULLY.

SIGNATURE (patient or parent if under 18 years of age) | DATE

HOW DID YOU HEAR ABOUT US?

EMERGENCY CONTACT (please list someone living at a residence other than those listed on page 1)

CONTACTS'S NAME | TELEPHONE (day) | TELEPHONE (night)

CONTACT'S ADDRESS | CITY | STATE ZIP | RELATIONSHIP TO PATIENT

Print Form

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.

YOUR ESTIMATED PORTION WILL BE DUE AT THE TIME SERVICES ARE RENDERED.

If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including medicare, private insurance and other health plans to the practice named on page 1 of this form.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

THANK YOU FOR YOUR COOPERATION