LINDSBORG FAMILY DENTAL CARE

Erik J. Peterson, DDS | 101 N. Harrison, PO Box 311 • Lindsborg, KS 67456-2204 (785)227-2299

Welcome to Lindsborg Family Dental Care

PATIENT REGISTRATION

Chart#: ____________

FOR OFFICE USE ONLY

Patient Name: ____________ * ____________ * ____

Last First MI

____
Preferred Name

Title: ____________ *
Mr/Ms/Mrs/etc

Gender: ◯ Male ◯ Female

Family Status: * ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: * ____________

SS#: ___-__-____

Prev. Visit: ____________

Email Address: ____________

Best time to call: ____________

Phone: ____________ * ____________ ____________ ____________

Home Mobile Work Ext

____________ ____________
Fax Other

Address: ____________ *
Address 1

____
Address 2

____________ * ____________ * _____-____ *
City State Zip Code

Name of Employer, phone number and address

____

____

In an emergency, who should be notified? Please enter name, phone number(s) and relationship. *

____

____

Whom may we thank for referring you to our practice?

____

INFORMATION FOR THE RESPONSIBLE PARTY
if other than the patient

Please complete the following information for the person financially responsible for the account. This must be completed if the patient is under 18, or under the care of a parent, guardian, or POA.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name:

______________________ Last ______________________ First ____ MI

______________ Preferred Name

Title: ________ Mr/Ms/Mrs/etc

Gender: ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ____________

SS#: ___-__-____

DL#: ____________________

Email Address: ______________________________

Best time to call: ______________

Phone:

__________ Home __________ Mobile __________ Work ______ Ext

__________ Fax __________ Other

Address:

______________________________ Address 1

______________________________ Address 2

______________________________ City ______ State _____-____ Zip Code

Name of Employer, phone number and address

____

____

Spouse's name (if not the patient) and phone number

____

____

PRIMARY DENTAL INSURANCE INFORMATION

Please provide all insurance cards to the receptionist so a copy can be made for our files.

Name of Insured:

Last

First MI

Insured's Birth Date:

ID #: **Group #:**

Insured's Address:

Address 1

Address 2

City

State Zip Code

Insured's Employer Name:

Employer Address:

Address 1

Address 2

City

State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address:

Address 1

Address 2

City

State Zip Code

Do you have secondary dental insurance? ◯ Yes ◯ No

☐ * **I verify that all the above information is correct to the best of my knowledge.**

Name and relationship of individual completing this form, if other than the patient: