Southpointe Dental
James Lichtsinn, DDS
3210 18th Street South
Fargo, ND 58104
Phone (701) 280-1941

PATIENT REGISTRATION

Thank you for trusting us with your dental care. We are a dental team committed to comfort and excellence. If you have any questions, please do not hesitate to ask.

Patient Information

Today's Date_____

First Name _____MI_____Last Name_____ DOB_____

Address_____City/State/Zip_____

Home Phone (_____) _____Work (_____) _____Cell (_____) _____

SSN___ _____ Gender: M F

Text Confirmations for appointments? Yes / No (circle one) **T-Mobile** **AT&T** **Verizon** **Sprint**

Would you like emailed appointment reminders? Yes / No Email: _____

Would you like online access to your account? *(requires email)* Yes / No

Employer_____ Occupation_____

Person to contact in emergency _____Phone (____) _____

How did you hear about our office? _____

Do any other members of your family come here for dental care? _____

*Person Responsible For This Account: _____ Relationship: _____

Dental Insurance Information (please bring your insurance card(s) to your appointment)

Policy Holder Name _____ DOB _____ Relation to Patient_____

Employer_____ Work Phone (_____) _____

Insurance Company _____ Address _____

Group number _____ Insurance ID number/**SSN**_____

Secondary insurance

Policy Holder Name _____ DOB _____ Relation to Patient_____

Employer_____ Work Phone (_____) _____

Insurance Company _____ Address _____

Group number _____ Insurance ID number/**SSN**_____

Authorization and Release

I authorize and request my insurance company to pay directly to Southpointe Dental any insurance benefits otherwise payable to me. I authorize Southpointe Dental to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. In addition, I authorize Southpointe Dental to use anonymous photos of my teeth for publications, web pages and other educational materials produced and representing Southpointe Dental without compensation to me. I authorize contact from this office to confirm appointments, treatment and billing information via Phone, Email or Fax

_____ _____

Signature of patient (or guardian if minor) Date