PATIENT REGISTRATION

Southpointe Dental
James Lichtsinn, DDS

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? _____

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 _____

Insurance ID number / SSN_____ Group number _____

Secondary insurance

Policy Holder Name _____ DOB _____ Relation to Patient_____

Employer_____ Work Phone (_____) _____

Insurance Company _____ Address _____

Insurance ID number / SSN_____ Group number _____

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.

By sharing my Cell Phone, Home Phone, Address, Work Phone and/or Email, I am giving Southpointe Dental permission to contact me via one of these methods to relay information concerning my appointments, treatment information, billing information and/or information about my dental health. If I do not wish to be contacted by one of these methods, I will advise Southpointe Dental. 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.

_____

Patient, Parent or Guardian Signature Date

_____

Relationship to Patient if Applicable