Lundell & Hoy DENTISTRY

Chris B. Lundell, DDS, PC
Ellen P. Hoy, DDS
Benjamin C. Lundell, DDS

ADULT PATIENT REGISTRATION

First Name:_____ Middle Initial:_____ Last Name:_____

Preferred Name:_____ Date of Birth:_____Gender:_____ Male _____ Female

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

Home Phone:_____ Cell Phone:_____ Would you like text appointment reminders? YES NO

Email: _____ May we contact you via email? YES NO

Social Security #:_____ Maritial Status: ____Marrried ____Single ____Divorced ____Separated ____Widowed

Employer:_____ Work Phone:_____ May we contact you at work? YES NO

How did you hear about our office? ___Family___Friend___Newspaper ___Website____Phone Book___Television
Other:_____

PERSON RESPONSIBLE FOR ACCOUNT

First Name:_____ Middle Initial:_____ Last Name:_____

Relationship of responsible party to patient ____ Self ___ Spouse ___ Father ___Mother ___Guardian
If the responsible party is other than the patient, please complete the remainder of this information.

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

Employer:_____ Home Phone:_____ Cell Phone:_____

DENTAL INSURANCE – Please bring your insurance card to you appointment.

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Phone #_____

Group/Plan #:_____ ID #_____

Insured's Name:_____

Relationship to Insured: ___Self ___ Spouse ___Child ___ Other

Insured's DOB:_____ Insured's SSN #_____

Insured Employer:_____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Phone #_____

Group/Plan #:_____ ID #_____

Insured's Name:_____

Relationship to Insured: ___Self___Spouse ___Child___Other

Insured's DOB:_____Insured's SSN #_____

Insured Employer:_____

Consent: I authorize the doctors and staff at Lundell and Hoy Dentistry to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis and to perform any and all forms of treatment, medication, and therapy that may be indicated. I understand that my dental insurance is a contract between the insurance carrier, and me and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time of services rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees incurred.

Signature of Patient, Parent, or Guardian

Date