Patient Information

Name (First, MI, Last): _____

Circle all that apply:
Married Single Minor Male Female

Address: _____ City, State, Zip: _____

Birthdate: _____

SS#: _____

Contact Information:
Home: _____ Cell: _____ Work: _____

Email: _____

Place of Employment:
_____

Please name the person responsible for this account and your relationship, if other than yourself:

_____

Please name someone we may contact in the event of an emergency:

_____Relationship: _____ Phone: _____

Has any member of your family been treated in our office? _____

Who may we thank for referring you to our office? _____

Are you currently or have you in the past been treated for a heart murmur, joint replacement surgery, or any other medical condition that requires antibiotic pre-medication prior to dental treatment?
Yes No If Yes, Please explain._____

Payment

Please indicate the method of payment for today's and future appointments:

____ Payment in full at each appointment (cash or check) will be eligible for a 5% discount.

____ Payment in full at each appointment with Visa, Mastercard, or Discover.

____ Payment uttilizing CareCredit Financing (if eligible).

Insurance Information

Primary Insured / If no insurance, complete for responsible party

Name: _____

Address: _____ City, State, Zip: _____

Home Phone: _____

Relationship to patient: _____

Employer: _____

Dental Insurance Co: _____

SS#: _____ Birthdate:_____

Subscriber #: _____ Group #: _____

Secondary Insured

Name: _____

Address: _____ City, State, Zip:_____

Home Phone: _____

Relationship to patient: _____

Employer: _____

Dental Insurance Co: _____

SS#: _____ Birthdate:_____

Subscriber #: _____ Group #: _____

I hereby authorize payment directly to Lyman Family Dentistry of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Lyman Family Dentistry to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

Signed: _____ Date: _____

Patient or Legal Guardian