Lampkin Family Dentistry

New Patient Information (Please print)

Patient's Name _____ Date of birth _____Age_____

SSN# _____ Street Address: _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Marital Status (circle one): Single, Married, Widowed, Divorced, Separated

Parent's Name (if patient is a minor) _____

Parent Address (if different from patient) _____

City _____ State _____ Zip _____

Employer _____ Phone: _____

Employer Address:_____

City _____ State _____ Zip _____

Occupation: _____ How Long Employed_____

Person Responsible for Payment _____ Phone_____

Who may we thank for referring you? _____

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

Name of nearest relative **NOT** living with patient _____

Relationship_____ Phone_____

Address: _____ City _____ State _____ Zip _____

ALL CHARGES ARE DUE AT THE TIME OF SERVICE. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

Do you have Dental Insurance? _____Name of Ins. Company _____

Policy # _____ Group # _____

Other Dental Ins. _____ Policy # _____Group # _____

Name of Policyholder _____ ID# _____

PLEASE COMPLETE THE BACK

Full Time Student, School and City

_____

This is to certify that I accept full responsibility for all charges resulting from services ordered personally and those ordered by the dentist attending me. In the event that the patient or his agents default in payment, and the account is placed in the hands of a collector or an attorney for collection, I further agree that all collection, attorney, and all other expenses will be paid by the patient or his/her agent or guarantor.

Date _____

Signature _____

Witness _____

Signature _____