# LAWHON DENTAL

## TANYA P. LAWHON, DDS

### REGISTRATION FORM

(Please Print)

| Today's date: | ***REASON FOR VISIT:*** |
|---|---|

## PATIENT INFORMATION

| Patient's last name: | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Ms. ❑ Dr. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|---|

| | Preferred name/nickname: | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F |
|---|---|---|---|---|---|

| Street address: | Social Security no.: | Home phone no.: ( ) |
|---|---|---|

| City: | State: | Zip Code: | Cell phone no.: ( ) |
|---|---|---|---|

| Email: | Employer: | Employer phone no.: ( ) |
|---|---|---|

Who may we thank for your referral?
Name:_____

❑ Family ❑ Friend ❑ Close to home/work ❑ Newspaper ❑ Other

Other family members seen here: **Spouse's Name:** DOB: / / Phone Number: ( )

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

| Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( ) |
|---|---|---|---|

Is this person a patient here? ❑ Yes ❑ No

| Occupation: | Employer: | Employer address: | Employer phone no.: ( ) |
|---|---|---|---|

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate **primary** insurance

| Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $ |
|---|---|---|---|---|---|

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

| Name of **secondary** insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.: |
|---|---|---|---|

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

## IN CASE OF EMERGENCY

| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Lawhon. I understand that I am financially responsible for any balance. I also, authorize Lawhon dental or insurance company to release any information required to process my claims. I was given a copy of the HIPPA policy, Lawhon Dental Financial Policy and Insurance Assignment policy to read.

**I have read and understand the policies regarding HIPPA, Financial Policy, Failed Appointments and Insurance Assignment.**

*Patient/Guardian signature* *Date*