LeMars Dental Center
1311 Hawkeye Ave SW
LeMars, IA 51031
(712) 546.5183

Patient Registration

Patient Name	Gender ❑ Male ❑ Female	Today's Date
Address		
City	State	Zip
Home Phone	Work Phone	Cell Phone
Date of Birth	SS#	Marital Status ☐Minor ☐ Widowed ☐Single ☐ Divorced ☐Married
E-mail address	Employer	
Person to call in case of emergency	Whom may we thank for referring you?	
Patient's Parent/Spouse Name	Employer	Work Phone#

Responsible Party/Insurance Information

Person Responsible for this Account	Relationship to Patient	Phone #
Address	City/State	Zip
Date of Birth	Social Security #	Cell Phone #
Insured's Name	Social Security #	DOB:
Employer Name and Address		Work Phone
Insurance Company	Group #	Subscriber #

Medical or Secondary Dental Insurance Information

Insurance Company		
ID#:	Group #	
Subscriber's Name	Subscriber's SS#:	Subscriber's DOB:
Employer Name and address		

Please complete other side.

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made in advance. In the event payments are not received by agreed upon dates, I understand that a 1-1.5% finance charge (18% APR) may be added to my account. I understand that should my account be sent to collections, I am responsible for any collection charges that will incur.

Signature of Patient or Responsible Party **Date**

Relationship to Patient

AUTHORIZATION AND RELEASE

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor 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. I have read and answered the above questions to the best of my knowledge.

Signature of Patient or Responsible Party **Date**

Relationship to Patient