Welcome to Royal Lakes Family and Cosmetic Dentistry
New Patient Registration

Today's Date: ____________

Who may we thank for referring you to our office: ____________

Patient Information:

Patient is: Policyholder/Responsible Party/Patient Date of Birth: ____________

First Name: ____________ **Last Name:** ____________ **M.I.** ________ M /F

Address: ____________
City State Zip

Employer: ____________ Phone: ____________

If patient is a minor: Guarantor Name: ____________ *DOB* ____________

Person responsible for account: ____________

Home Phone: ____________ Cellular: ____________ Work:

Drivers License#: ____________ Marital Status: Married/Single/Divorced/Separate/ Widowed

Email Address: ____________ Social Security Number: ____________

Would you like to receive: Emails / Text Message Do you use Social Media: Yes / No
Y /N Y/N

Are you a full-time student: Y / N

Emergency Contact: Name and telephone number: ____________

Primary Insurance:

Named of Insured: ____________ DOB: ________ SSN: ____________
Relationship to Insured: Self / Spouse / Child / Other Employer: ____________
Insurance Company: ____________
Insurance Company Address: ____________
City State Zip
Insurance Company Phone: ____________ Phone: ____________
ID#: ____________ Group #: ____________

Secondary Insurance:

Named of Insured: ____________ DOB: ________ SSN: ____________
Relationship to Insured: Self / Spouse / Child / Other
Employer: ____________
Insurance Company: ____________
Insurance Company Address: ____________
City State Zip
Insurance Company Phone: ____________ Phone: ____________
ID#: ____________ Group #: ____________