Steven S. Lawson DDS INC
Creating Healthy Smiles

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Patient Registration

Patient Name_____Date_____
First MI Last

Address_____ City _____ Zip _____

Home phone (_ _____)_____ Cell phone (_____)_____ Do you text message? Yes No

Date of Birth _____ Male____ Female ____ Married ____ Single____

E-mail address _____ Can we confirm appointments by e-mail? Yes No

IF PATIENT IS UNDER 18 YEARS OF AGE

Father's Name_____

Address_____

City_____ Zip_____Phone _____

Employer_____Phone_____

Mother's Name_____

Address_____

City_____ Zip_____Phone _____

Employer_____Phone_____

Patient: Employer_____ Occupation_____

Work Phone _____ Can be called at work? Yes___ No ___

Spouse: Employer_____ Occupation_____

Work Phone _____ Can be called at work? Yes___ No ___

INSURANCE (If insurance card is given, no need to complete)

Primary

Insurance Company _____

Name of Insured _____

ID # _____ Date of Birth_____

Secondary

Insurance Company _____

Name of Insured _____

ID # _____ Date of Birth_____

Who can we thank for referring you to our practice? _____

IN CASE OF AN EMERGENCY WHO SHOULD WE CONTACT?

Name_____

Phone (_____) _____