Welcome to Lakefront Dental
Lillian Obucina DDS, PC

Patient Information:

First Name:_____ Last Name: _____ Middle Initial: ____

Birth Date: _____ Social Security Number: _____ Sex:_____

Address: _____ Apt. Number: __

City: _____ State: _____ Zip: _____

Mobile: (_____)_____-_____ Home: (_____)_____-_____ Work: (_____)_____-_____

Email:_____

Employer: _____

Emergency Contact: Name: _____ Mobile: (___)____-_____ Relation: _____

Who referred you? _____
_____

Responsible Party if Someone Other Than Patient:

First Name:_____ Last Name: _____ Middle Initial: ____

Address: _____ Apt. Number: ___

City: _____ State: _____ Zip: _____

Mobile: (_____)_____-_____ Home: (_____)_____-_____ Work: (_____)_____-_____
_____

Insurance Information (please provide insurance card):

Name of Policy Holder: _____ Policy Holder Birth Date: _____

Relationship to Patient: _____

Policy Holder Address: _____ Apt. Number: ___

City: _____ State: _____ Zip: _____

Policy Holder Social Security Number/ID Number: _____

Policy Holder Employer: _____

Name of Insurance Company:_____

Insurance Company Address_____

City: _____ State: _____ Zip: _____

Insurance Company Phone Number: (_____)_____-_____ Group Number: _____

_____

Social Media: We would like to share with you timely dental hints, office news, and/or office promotions through social media. Please find us by searching for Lakefront Dental. Also, we appreciate your reviews online to assess how we are doing!

Photography and Radiography (X-rays): Your before and after images may be used for educational purposes in office or online. We make every effort to conceal your identity in these photos or radiographs. Please let us know if you object to this use. By signing below, without alerting us of your objection, you are agreeing to this limited use for educational purposes in office or online.

Financial Policy:
Our primary mission is to provide the best dental care available, while making the cost of optimal care easy and manageable for our patients.

We offer **interest free financing through CareCredit** (subject to approval). In addition, payments can be made using cash, VISA, MasterCard and American Express.

For patients with **dental insurance**, we are in network providers for some insurances and out of network providers for others. We do accept all PPO plans but coverage will vary based on in or out of network status. We will file all your insurance claims for you, but it is **your responsibility to pay all deductibles, copayments, and other balances not paid by your insurance carrier.** If you have any concerns about your coverage, upon request, we will submit an insurance pre-estimate to your insurance for you, prior to starting any treatment.

Signature of Patient or Guardian: _____ Date: _____
This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to Lillian Obucina DDS, PC the benefits otherwise payable to me.

Signature of Patient or Guardian: _____ Date: _____