Keely N. Lawson D.D.S., P.A.
General Dentistry

414 W. Pleasant Run Rd.
Lancaster, Texas 75146
P 972-227-5444 F 972-227-5332
www.drklawson.com

Registration

Date: _____

Patient Name: (First, M.I., Last) _____

Parent/Guardian Name: (when applicable)_____

Street Address:_____

City: _____ State:_____ Zip: _____

Birth Date:_____ Age: ___ Gender: ___ Social Security Number: _____

Home Phone Number: _____ Cell Phone Number: _____

Place of Employment:_____

Work Phone Number: _____ E-Mail Address: _____

Physician's Name: _____ Phone: _____

In Case of an Emergency Call:_____

Phone Number:_____ Relationship:_____

Do you have Dental Insurance? ◯ Yes ◯ No *If yes, please present card.*

Insurance Company Name:_____

Insurance Type: ◯ PPO ◯ HMO ◯ Other

How did you learn about our office? _____ *Please Answer.*

Did you locate us via the Internet? ◯ Yes ◯ No

The undersigned hereby authorizes the Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am fully responsible for all dental fees. These fees are due and payable at the time services are rendered.

Patient/Guardian Signature:_____ Date: _____