Welcome!

ANDERSON LAKE DENTAL REGISTRATION FORM

Patient Information **Date_____**

Name: _____ I Prefer to be called: _____
Address: _____City:_____State:_____Zip_____
Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____
Email Address: _____
Date of Birth: _____ Social Security Number: _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Spouse or Parent's Name: _____ Employer_____ Work Phone_____
How did you hear about our office? _____
Person to contact in case of emergency_____ Phone_____

Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name: _____ Relationship to Patient: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: (____) _____
Employer_____ Work Phone (____) _____ SSN#_____

CONSENT TO USE PHOTOGRAGHS

I, _____ (patient or Parents name) herby authorize Anderson Lake Dental to take photographs, and/or videos of my face, jaw and teeth, before, during and after treatment.

I consent for the photograph and/or videos to be used for the following:

- *Dental Research*
- *Dental Educations including lectures, seminars, professional publications such as journal or books*
- *Marketing material, including websites, Facebook, printed material and patient education.*

I further understand that if the photograph and/or videos are used, my name or any other identifying information **will be kept confidential**.

_☐_ Check here if you do **not** want your full face shot used for any of the above purposes.

_☐_ Check here if you do **not** want us to use any photos/videos for any of the above purposes.

Patient Name (Print Please): _____

Patient or Guardian Signature: _____ Date: _____