Welcome To Our Practice

Dr. Craig B. Lashley, D.D.S.
Dr. Alexandra Seltenreich, D.D.S.
Dr. Rebecca Twietmeyer, D.D.S.

Patient Information

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Single ☐Married

First Name__________ M.I.______ Last Name__________ Pref Name:__________

Male/ Female D/O/B__________ SSN__________ Driver's Lic. #__________

Street__________ City__________ State______ Zip__________

Primary Phone: Home/ Cell__________ Email__________

Employer__________ Bus. Tel.( ) __________ Ext:____ Department:__________

Patient Student Status: ☐Full Time ☐Part Time ☐None School Name__________
(City, State, Zip)

I consent to receive electronic communications between Lashley Family Dentistry and myself at the number and/or email listed above: ☐ **YES** ☐ **NO**

Who will be responsible for this account? ☐Self ☐Spouse ☐Father ☐Mother ☐Other__________
(If self, skip to next section)

First Name__________ Last Name__________ SSN__________ D/O/B__________

Street__________ City__________ State__________ Zip__________

Employer__________ Bus. Tel.( ) __________ Alt. Tel.( ) __________
☐Full Time ☐Part Time ☐Self ☐Retired

Have you or a **member of your household** been seen in our practice? ☐No ☐Yes, If yes whom?__________

Verbal communication between our office and the individuals named below are allowed:

Name:__________ Relationship:__________ Phone No.:__________
☐ All Dental ☐ Treatment ☐ Billing/ Accounting

Name:__________ Relationship:__________ Phone No.:__________
☐ All Dental ☐ Treatment ☐ Billing/ Accounting

Name:__________ Relationship:__________ Phone No.:__________
☐ All Dental ☐ Treatment ☐ Billing/ Accounting

Primary Dental Insurance Information

Policy Holder's Name__________ D/O/B__________ SSN or ID#__________

Relationship to Patient ☐Self ☐Spouse ☐Child ☐Other ☐Married ☐Divorced ☐Separated ☐Widow ☐Single

Employer Name__________ Policy Group Number__________

Insurance Carrier Name, Address & Tel.__________

Insured's Address/ Phone (*if different from above*)__________

Secondary Dental Insurance Information

Policy Holder's Name__________ D/O/B__________ SSN or ID#__________

Employer Name__________ Policy Group Number__________

Insurance Carrier Name, Address & Tel.__________

Insured's Address/ Phone *(if different from above)*__________

Person to Contact in Case of Emergency: ***(not within same household)***

Name of Emergency Contact__________ Relationship:__________ Tel. ( ) __________