STEPHEN R LEE DDS JOSEPH VAN MIEGHEM DDS RALPH G STENBERG DDS
19718 - 68TH Avenue W Suite G Lynnwood, WA 98036

Preventive • Restorative • Cosmetic • Dentistry

Welcome to our office

About You

Today's Date _____

Patient Name

_____
Last First M

What You Prefer to be Called _____
Birthdate _____ Age _____
Social Security # _____
Mailing Address _____

_____
City State Zip

Home Phone # _____
Work Phone # _____
Cell Phone # _____
e-mail Address _____

Referred By _____

Employer _____
How Long? _____
Employer's Address _____

_____
City State Zip

Occupation _____

Status: Single ___ Married ___ Divorced ___ Widowed ___

Spouse's Name _____

Do you have children? Yes ___ No ___ How many? _____

Account Information

Person responsible for account

Name _____
Relationship _____
Billing Address _____

_____
City State Zip

Social Security # _____
Drivers License # _____
Work Phone # _____
Home Phone # _____

Insurance Information

Primary Dental Insurance

Insurance Carrier _____
Group Plan # _____
Phone # _____
Insured's Name _____
Relation _____
Date of Birth _____
Insured's SS# _____
Insured's Employer _____

Secondary Dental Insurance

Insurance Carrier _____
Group Plan # _____
Phone # _____
Insured's Name _____
Relation _____
Date of Birth _____
Insured's SS# _____
Insured's Employer _____

In Event of Emergency

Who should we contact? _____
Relationship: _____
Home Phone # _____
Work Phone # _____
Cell Phone # _____
Who is your MEDICAL DR.? _____
M.D.'s Phone # _____

Please continue on back →

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on friendly, mutual understanding between provider and patient.

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collection of your unpaid balance.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims; for additional specialist consultation; or in the event I request my records to be transferred to another dental office.

- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date_____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse