Welcome

Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions we'll be glad to help. (Please Print)

Nancy Kate von Lackum, DMD, PhD. ~ 620 Perimeter Dr. Suite 201 ~ Lexington, KY 40517 ~ 859-269-0070

CONFIDENTIAL PATIENT INFORMATION

Name____ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Rev. [ ] Other: ________
First MI Last
Address__________________________________Occupation:_________________________ [ ] Male [ ] Female
City___________________________________State__________Zip__________ Hm# (__) _______________
Employer ____ Wk # (__) _______________
Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated Cell # (__) _____________
DOB: ____/___/____SSN#____________________ Email ____________________________@_________
Spouse's Name ____ Pharmacy: ______________________
First MI Last (if different) General Dentist _________________
Spouse's Occupation ______________________________________ Work Phone ________________Ext______
Is patient a full time student? [ ] No [ ] Yes: Name of School ____

RESPONSIBLE PARTY (if different than patient)

Name ____
First MI Last
Address ____
City ____________________State_______ Zip________
Hm#_________________________
Wk# _________________________
DOB: ____/______/____________
SSN#_________________________
Relationship: _________________

About Dr. von Lackum:
Doctor of Dental Medicine, University of FL College of Dentistry
PhD in Microbiology, University of Kentucky
Diplomate of the American Board of Periodontology,
A Recognized Specialty of the American Dental Association
Fellow of the International Congress of Oral Implantologists
Alumni: L. D. Pankey Institute for Advanced Dental Education, Implant prosthetic Section of ICOI, Academy of Osseointegration

YOUR PREFERENCES
Do you prefer appointment reminders by: [ ] Email [ ] Phone
Do you prefer to receive calls from our office at: [ ] Home [ ] Work [ ] Cell
Whom may we thank for referring you? How do you wish to be addressed by our staff?
__________________________ _____________________________

INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriber's Name _______________________________________Relationship to Patient: ___________________
DOB: ______/_______/________ Subscriber's SSN# __________________________
Insurance Company _________________Policy # ____________________________Group # _______________

DENTAL INSURANCE:

Insured Name _______________________________ Relationship to patient: _________________
Address ____________________________________ City_______________State_____Zip______
DOB: _____/____/_____ SSN# _______________Employer:____
Insurance Company: ___________________________ Group # _______________ Eff. Date: _____/____/_____
DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [ ] Yes [ ] No If yes, please complete the following:
Insured Name _________________________________ Relationship to Patient: _________________
Address ______________________________________ City ________________State ____Zip ______
DOB: _____/_______/_________SSN# _______________Employer: __________________________________
Insurance Company _________________________________Group#________________Eff. Date ___/___/____

Our practice offers **CT 3D Advanced Imaging** to provide you with the latest in technology for maxillofacial reconstructive surgery and dental implant treatment in Kentucky.

"Our Practice is dedicated to the most modern and advanced techniques while providing the highest level of gentle care for our patients".

Kate von Lackum, DMD, PhD