



LANAP LASER TREATMENT PATIENT REGISTRATION

DATE: _____

PATIENT NAME: _____
FIRST LAST

ADDRESS: _____

HOME TEL: _____

WORK TEL: _____

CELL NUMBER: _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____

Do you have Dental Insurance? YES NO

If so what is it? _____

Who is your primary General Dentist?

Dentist name: _____

Address: _____

Office Number: _____

Where did you hear about us?

Our Website Heard On the Radio Newspaper/Magazine Ad

Search Engine WUSA 9 TV

Patient Referral

From: _____

Dental Referral

From: _____

PLEASE SIGN HERE: _____

DATE: _____

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