WELCOME

Thank you for selecting **LUX DENTAL**

We will strive to provide you with the best possible dental care. To help us meet all your dental needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us.

DATE ____/____/_____

PATIENT INFORMATION (CONFIDENTIAL)

Name:	Sex: ◻ Male ◻ Female
Address:	Check appropriate box: ◻ Minor ◻ Single ◻ Married ◻ Other
City:	**Date of Birth: MM/DD/YY** ____/_____/______
State: Zip:	**Soc. Sec. #**
Cell Phone:	**Email:**
Home Phone:	Whom May We Thank for Referring You?
PERSON TO CONTACT IN CASE OF EMERGENCY	**DO YOU HAVE DENTAL INSURANCE?** ◻ YES ◻ NO
Name:	Name of Insurance Carrier:
Address:	Employee/Subscriber Name:
City:	Date of Birth:
State: Zip:	Subscriber Soc. Sec. #
Best phone number to reach them:	Insurance Phone:

EMPLOYMENT INFORMATION

Employer:	Business Address:
Work Phone:	City: State: Zip: