Lucia Family Dentistry
Patient Information

Name_____ Date_____

Address_____

City, State, Zip Code_____

Date of Birth_____/_____/_____ Social Sec. # _____-_____-_____

Contact Information: Circle preferred way to reach you.
Cell #_____ Work #_____ Home # _____
Email address_____

Emergency Contact _____ Cell #_____

Who is financially responsible for your account?_____
Who may we thank for referring you to our office?_____
The best way to contact me during the day is:_____
Do you have a preference for an appointment time? Day_____a.m. or p.m.

Marital Status (Circle one that applies): Single Married Separated Divorced Widowed

Employment Status: Full Time Part Time Other Retired

Employer:_____Occupation:_____

Student: Full Time Part Time School:_____

Do you have Dental Insurance? YES NO
Policy Holder_____Policyholder Date of Birth_____
Group/Plan Policy#_____
Relationship_____
Employer_____
Insurance Co._____
Do you have Secondary Dental Insurance: YES NO
If YES, please provide information:
Policy Holder_____ Policyholder Date of Birth_____
Relationship_____
Employer_____
Insurance Co._____Group/Plan Policy#_____

I am financially responsible for my account at Lucia Family Dentistry. I understand if the provider receives and insufficient funds notice of any payment on my account, there will be a $25 service charge.

Signature:_____Date:_____