Welcome to **LUCK DENTAL CENTER**

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

Patient Name: _____ I prefer to be called: _____
Date of Birth: _____ Social Security # _____
Sex: __Male __Female __ Other Preferred Pronouns: _____
Address: _____ Preferred Phone #:( ) _____
_____ Alternate Phone #:( ) _____
Email Address: _____
What preference do you have when confirming appointments? ___ Text ___ Email ___ Both
Emergency Contact Name: _____ Phone #:(__)_____

Previous Dentist: _____ Date of last dental visit: _____
Name of physician: _____ Date of last doctor visit: _____

Primary Dental Insurance Information:
Insured Name: _____ Date of Birth: _____ Relation to Patient: _____
Insured Address: _____ Phone #: ( ) _____
_____ Employer: _____
Insurance Company Name: _____ Group Number: _____
Insurance Address: _____ ID or SSN #: _____
_____ Phone #: ( ) _____

Secondary Dental Insurance Information:
Insured Name: _____ Date of Birth: _____ Relation to Patient: _____
Insured Address: _____ Phone #: ( ) _____
_____ Employer: _____
Insurance Name: _____ Group Number: _____
Insurance Address: _____ ID or SSN #: _____
_____ Phone #: ( ) _____

Name of person responsible for payment: _____
Address: _____ Name of Employer: _____
Phone: ( ) _____ Employer Address: _____
Date of Birth: _____ _____

How did you learn about our office? _____

So that we can give you the best possible experience in our office, is there anything about having dental treatment that you would like us to know? _____
_____