Welcome to the office of **Anna Lu, D.M.D.**. In order to serve you properly, we need the following information.
All information will be confidential. **Please print.**

Patient Information

Date _____ Patient name _____ Dr Mr Mrs Miss Ms
Last First Middle Please circle the appropriate title.

SS# _____ ❑ Male ❑ Female Date of Birth _____ Home phone # _____

Address _____ City _____ State _____ Zip _____

Check appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated Occupation _____

Patient's employer _____ Work phone # _____ Ext: _____

Employer's address _____ City _____ State _____ Zip _____

Is the patient a full-time student? Y / N School _____ City & State _____

Who may we thank for referring you? _____

Person to contact in case of emergency? _____ Phone # _____

Responsible Party

Name of person responsible for this account. _____ Dr Mr Mrs Miss Ms

Relationship to patient. _____ SS# _____ Date of Birth _____ Home phone # _____

Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Work phone # _____ Ext: _____

Employer's address _____ City _____ State _____ Zip _____

Has this person previously been a patient in our office? Y / N

Insurance Information

Name of insured: _____ Relationship to patient: _____

SS# _____ Date of Birth _____

Employer _____ Occupation _____ Work phone # _____ Ext: _____

Employer's address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Ins. phone # _____

Insurance address _____ City _____ State _____ Zip _____

How much is your Deductible? _____ What is your Max. annual benefits? _____ How much have you used? _____

Do you have any additional insurance? Y / N If yes, please complete the following:

Name of insured: _____ Relationship to patient: _____

SS# _____ Date of Birth _____

Employer _____ Occupation _____ Work phone # _____ Ext: _____

Employer's address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Ins. phone # _____

Insurance address _____ City _____ State _____ Zip _____

How much is your Deductible? _____ What is your Max. annual benefits? _____ How much have you used? _____

Medical Insurance Company: _____ ID# _____

Your careful answers will expedite reimbursement by your insurance company. Claims are commonly delayed or returned for incomplete information. As a service to you, we will prepare the necessary forms or reports to help obtain your benefits. We do not render services on the basis that insurance companies will pay our fee. *The patient is responsible for any charges not covered and/or denied by the insurance carrier.* _____(Please initial.)

X _____ Date _____