

# WELCOME

**Dennis R. Lucas, D.M.D.**

**Our goal is to help you reach and maintain maximum oral health. You will be provided with an office brochure so that we may better serve you. Thank you for filling out this form completely.**

## ABOUT YOU

Today's Date: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Name: \_\_\_\_\_

I like to be called: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Mailing Address, If different: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Your Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Birthday: \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_

Special interest, sports or hobbies: \_\_\_\_\_  
\_\_\_\_\_

Referred by: \_\_\_\_\_

## DENTAL INSURANCE

Do you have dental insurance through your employer?

Yes \_\_\_ No \_\_\_

If yes, please provide the following information:

Dental Insurance Co. #1: \_\_\_\_\_

Group #: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Your Employer's Name: \_\_\_\_\_

Do you have any other Dental Insurance Coverage?

Yes \_\_\_ No \_\_\_

This coverage is through:

Spouse \_\_\_ Parent \_\_\_ Other \_\_\_

Their Name: \_\_\_\_\_

Their Employer's Name: \_\_\_\_\_

Their Social Security #: \_\_\_\_\_

Their Birthdate: \_\_\_\_\_

Dental Insurance Co. #2: \_\_\_\_\_

Group #: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

## TELEPHONE

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Email Address: \_\_\_\_\_

When is the best time to reach you? \_\_\_\_\_ Where? \_\_\_\_\_

In the event of an emergency, is there someone who lives near you that we could Contact?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Work #: \_\_\_\_\_ Home #: \_\_\_\_\_