ALLURE AD DENTAL

Thank you for selecting our practice to serve your dental health needs. It will be our pleasure to provide you with the best possible dental care. To help us achieve that goal, please complete this form completely. If you have any questions or need assistance we will be happy to help.

Doctor Preference ___ Dr. Murray ___ Dr. Mazur ___ No Preference

Patient Information - *Confidential*

Today's Date _____

Name _____ Home Phone _____ Cell Phone _____

Preferred Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ Email Address _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated

Students - Name of School _____ City _____ State _____ Full-time or Part-time

Employer _____ Dept. _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Spouse's Employer _____ Work Phone _____

Name of Nearest Relative Not Living with you? _____

Whom may we thank for referring you? _____

What hobbies do you enjoy? _____

Responsible Party (if different than above)

Person Responsible for Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Social Security # _____ Birthdate _____

Employer _____ Work Phone _____

Is this person currently a patient of this practice? Yes or No *(please circle appropriate answer)*

Insurance Information (Dental Insurance Only)

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____

Ins. Company Address _____ City _____ State _____ Zip _____

DO YOU HAVE ADDITIONAL DENTAL INSURNACE? Yes or No *If yes, complete the following:*

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____

Ins. Company Address _____ City _____ State _____ Zip _____