New Patient Registration Form

Welcome to Healthy Life Dental

Dr. Elaine Lu, D.D.S.

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Date: _____ Home Phone:_____ Cell Phone: _____

Patient Information

Name: _____ Social Security No/HIC/Patient ID#: _____
Last Name First Name Middle Initial

Address: _____ Email: _____

_____ City: _____ State: _____ Zip: _____

Sex: Male / Female Age: _____ Birthdate: _____

Minor / Single / Married / Separated / Divorced / Widowed / Partnered

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ Phone: _____

Important Additional Information

Preferred Contact Method: Call cell / home / work / Text Message / e-mail. **Preferred Contact Time**: _____

How did you find us? Mail / postcard / Walk-by / Insurance / Internet Google / Yelp / Facebook / Blog / Video

/ Other website _____

/ Referral - whom may we thank for referring you? _____

/ Other _____

Are you a user of Google / Yelp / Facebook / Twitter / e-mail/ texting?

In case of an emergency, who should be notified? _____ Phone: _____

Primary Insurance

Person Responsible for Account: _____ Relationship to Patient: _____
Last Name First Name Middle Initial

Insurance: _____ Group #: _____ Subscriber #: _____ DOB#_____

Assignment & Release

I certify that I, and /or my dependent(s) have insurance coverage with the above-named Insurance Company(ies) and authorize payment directly to Healthy Life Dental of all insurance benefits, if any, otherwise payable to me for services rendered. I am aware that by signing below, I certify that all information is complete and correct. I understand that I am financially responsible for all charges whether or not paid by insurance, and for all services rendered on my behalf or my dependents. The above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize the use of my signature on all insurance submissions. This is my authorization for Healthy Life Dental to verify my credit history and provide others with information regarding my credit history to the extent permitted by law.

_____ _____
Signature of Patient, Parent, Guardian or Person Responsible Date

_____ _____
Please Print Name of Patient, Parent, Guardian or Person Responsible Relationship to Patient