LIGHTHOUSE DENTAL-Constant Lu DDS, PC

3205 NE 78TH St. Suite 11 Vancouver WA 98665
360-576-3570

Patient Name: ____ Today's Date: _____________
Date of Birth: ______________ Social Security Number: ________________
Phone Number: ________________ Email address: _________________________________
Patient's Address: ____

Responsible Person If Different Than Patient: _______________________________________
Date of Birth: ______________ Social Security Number: ________________
Phone Number: ________________ Email address: _________________________________
Responsible Person's Address:____

Employer: _________________________________ Phone Number: _________________
Employer Address:#____
Insurance Company: _________________________ Phone Number:__________________
Group Number: ___________________________ Policy Number: _____________________
Address: ____

Spouse's Name: ___________________________ Date of Birth: _______________________
Phone Number: ____________________________ Social Security Number: ______________
Employer: _________________________________ Phone Number: _________________
Employer Address:#____
Insurance Company: _________________________ Phone Number:__________________
Group Number: ___________________________ Policy Number: _____________________
Address: ____

Emergency Contact: ___________________________________ Phone Number: ____________
Contact Other Than Family: __________________________ Phone Number: ______________
Whom May We Thank For This Referral:____
Hobbies or Special Interests: ____

Do you have any Special Requests that can help you feel more comfortable about your Dental Visits with us?
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I authorize the Dental Staff to perform any necessary dental services, with my informed consent, that I may need during diagnosis and treatment. I also acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payments of benefits.

Signature:____ Date: ________________