# ST. LUCIE CENTER FOR COSMETIC DENTISTRY

First Name:_____ Last Name:_____

Address:_____Apt:_____

City:_____ State:_____ Zip:_____

Home #_____ Cell #_____ Work#_____

Age:_____ DOB:_____ Soc Sec#_____ Sex: ☐ Male ☐ Female

Email: _____ Marital Status: Married ☐ Single ☐ Widowed ☐

How did you hear about us? _____Referred By: Patient _____

Employer:_____ Position:_____

Name of Primary Physican:_____ Phone:_____

Responsible Party : Self ☐ Other ☐ Name of Responsible party: _____

Relationship to patient: _____ DOB: _____ SSN:_____

In case of Emergency who should we notify?_____Phone _____

---

## Complete this section for Insurance Only

**Primary Insurance Information**

Name of Insurance :_____ Phone :_____

Name of Insured:_____ DOB:_____ SSN:_____

ID # _____ Group #_____

Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Insured Employer: _____ Phone:_____

Please provide us with your insurance card and driver's license/photo id

so we can make a copy for your chart. Thank you