

Myra C.Luna D.D.S., Inc.
50 S.Anaheim Blvd. Ste 86
Anaheim, CA. 92805
Tel:((714)774-7055 Fax:(714)774-0255

Welcome!

Thank you for choosing our office. We strive to protect you with the most gentle, quality care possible. If you have any questions, or we can help you in any way, please feel free to ask.

Name _____ (If child, parent/guardian name) _____
Last name First Name Initial
Birthdate _____ Sex _____ Age _____ Social Security # _____
Home Address _____ City _____ State _____ Zip code _____
Home Phone _____ Work Phone _____ Cell phone _____ Email _____
Driver's License # _____

Employer _____ Occupation _____ How long there? _____ May we call? _____
Employer Address _____ City _____ State _____ Zip code _____

Spouse's Name(Or other parent/guardian) _____ Social Security # _____
Spouse's Employer _____ Occupation _____ How long there? _____ May we call? _____
Spouse's Employer Address _____ City _____ State _____ Zip code _____

If patient is a student:Name of School/College _____ City & State _____ Full time or part time? _____
How did you hear about our practice? _____

Primary Insurance:

Name of Insured _____
Birthdate _____ Relationship to patient _____
Address(if different from patient) _____
Dental Insurance Co. _____ Phone _____
Social Security # _____ Subscriber ID# _____
Group, Contract or Local or Union _____

Additional Insurance:

Name of Insured _____
Birthdate _____ Relationship to patient _____
Address(if different from patient) _____
Dental Insurance Co. _____ Phone _____
Social Security # _____ Subscriber ID# _____
Group, Contract or Local or Union _____

Copaymenst:

To accept insurance, we now debit copayments automatically to your credit card or bank account, If you would like us to accept your insurance, please provide credit card information or voided check.

MC Visa Account # _____ Expiration date _____ Name on card _____
 Credit Card Debit Card ATM
 Voided check attached

In case of emergency:

Name and City of primary care physician _____
Someone we may contact, not living with you _____ Phone #s(home, work, cell) _____

Authorization:

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office, I authorize use of this signature for all insurance submissions.

I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary. I authorize this office to charge my credit card or bank account for any unpaid balances, including those after insurance payment. I understand that in certain circumstances, my credit report may be requested, I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that check payments may be converted to automatic bank drafts.

I have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date _____
Patient or Responsible Party