



# HAYES

GENERAL & COSMETIC DENTISTRY

## Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Responsible Party (if someone other than the patient) \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ Cellular: \_\_\_\_\_

E-mail Address \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed  Partnered  Other

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Drivers Lic. #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

### **Primary Insurance Information**

Insured Name: \_\_\_\_\_ Relationship to Patient:  Self  Spouse  Parent

Insured Date of Birth: \_\_\_\_\_ Insured Social Security Number #: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Group# \_\_\_\_\_ Insured ID#: \_\_\_\_\_

Claims Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Insurance Phone Number: \_\_\_\_\_ Employed by: \_\_\_\_\_

### **Secondary Insurance Information**

Insured Name: \_\_\_\_\_ Relationship to Patient:  Self  Spouse  Parent

Insured Date of Birth: \_\_\_\_\_ Insured Social Security Number #: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Group# \_\_\_\_\_ Insured ID#: \_\_\_\_\_

Claims Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Insurance Phone Number: \_\_\_\_\_ Employed by: \_\_\_\_\_

### **Authorizations:**

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize the release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize the release of any information concerning my health care, advice and treatment to another dentist.

I attest to the accuracy of the information on this page.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date