HAYES
GENERAL & COSMETIC DENTISTRY

Patient Registration

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: _____

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 Birht: _____ Insured Social Security Number #: _____

Insurance Carrier: _____Group#_____ Insured ID#: _____

Claims Address: _____ City, State, Zip _____

Insurance Phone Number: _____ Employed by:_____

Release:

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

I authorize 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 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 Signature Date