

# Patient Information



Hays Dental Group

Patient Information					
Patients Name					
Last	First			M.I.	
Address					
Street	Apt.	City		State	Zip
Contact Info.					
Home Phone		Cell/Pager #		Email Address	
When and where is the best time to reach you?				Daytime Phone Daytime Phone	
S.S.N.		Birth Date ____/____/____		Marital Status Male ____ Female ____	
Employer		Employers Address		Work Phone ext.	
Spouses Info.					
Last Name		First		M.I. Employer and Work Phone	
If patient is a minor, give parent's or guardian's name and Initial for permission to treat minor.				Is an immediate family member here? Yes / No	
Name		Initials _____		Name	
<b>Whom may we thank for referring you to our office?</b>					
Self Yes / No		Responsible Party Information			
If other than self, please complete:					
Last Name		First		M.I. S.S.#	
Address Street		Apt. City		State Zip	
(If less than 3 yrs at current) Previous Address		Home #		Work # Birth Date ____/____/____	
Disclosure of Dental Insurance					
Name of Insurance Provider			Group #		Group Name
Address of Company Street or P.O. Box		City		State Zip	
Contact Information Name (if applicable)			Phone # ext		Fax #
Emergency Information					
Name of nearest relative not living with you				Phone Number	
Address Street		Apt. City		State Zip	
I understand that when appropriate, credit bureau reports may be obtained.					
Signature (Responsible Party's signature if minor)					Date
Updates (Dates and Initial) _____					