DAVID D. HAYES, D.D.S.

PATIENT INFORMATION

Today's Date: _____-_____-_____

Birth Date: _____-_____-_____ Social Security #: _____-_____-_____

Patient Name:_____
(Last name) (First Name) (Middle Initial)

Street Address:_____

City:_____ State:_____ Zip Code:_____

☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Widowed ☐Domestic Partnership

Home Phone: (_____) _____ Work Phone: (_____) _____

Employer:_____ Office Phone: (_____) _____

EMAIL ADDRESS :_____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship:_____

Emergency Phone: (_____) _____

PRIMARY INSURANCE

Insured Name:_____
(Last name) (First name) (Middle initial)

Relationship to the patient:_____ Birth Date: _____-_____-_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Responsible Party Employed by:_____

Insurance Company:_____

Insurance company Address:_____

City:_____ State:_____ Zip Code:_____

Security/Employee ID #:_____ Group #:_____

(If you have a Secondary insurance, please let us know)