WELCOME TO HAYFIELD DENTAL CARE

Thank you for selecting our dental healthcare team!

We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help.

PLEASE COMPLETE IN INK ONLY.

Date ________________

Patient Information

Name ____

Address ____

City, State, Zip ____

Soc. Sec. No. ______________________ Birth Date __________________ Age ______________

☐ **Male** ☐**Female /** ☐**Minor** ☐**Single** ☐**Married** ☐**Divorced** ☐**Widowed** ☐**Separated**

Home phone No. __________________ Work phone _________________ Cell phone _________________

Employer ________________________ Occupation ________________________________

Business Address (Street, City, State, Zip) ____

Circle Responsible Party : Same as above Parent Guardian Other ______________

Who is responsible for the account?

Name ________________________________ Relationship to patient _____________________

Address ____

City, State, Zip ____

Birth Date _____________ Age _____ Driver's License # ______________ Soc. Sec. # __________________

Home phone No. __________________ Work phone _________________ Cell phone _________________

Employer ______________________________ Occupation __________________________________

Address (Street, City, State, Zip) ____

In the event of an emergency, who should we contact? ______________________

Relationship _________________________ Phone No. ___________________

Dental Insurance Information (Primary Insurance)

Insurance Company____

Address____

City, State, Zip ____

Phone No. ____________________________

Subscriber Name____

Relationship to patient ______________________

Subscriber Birth Date _______________Soc. Sec. No. ______________________

Member Number:____________________Group Number ____________________

Employer ____

(Secondary Insurance)

Insurance Company ____

Address____

City, State, Zip ____

Phone No. ____________________________

Subscriber Name ____

Relationship to patient ______________________

Subscriber Birth Date _________________ Soc. Sec. No. ____________________

Member Number:__________________Group No. __________________________

Employer ____

Authorization and Release:

I authorize the dentist to release any information including the diagnosis and the records to any treatment or examination and rendered to me or my child during the period of such dental care to third party payers and/or other health care providers. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services.

X____

Signature of Patient or Parent if minor   Date