HEYS DENTAL
EST 1972

Patient Information Sheet

Date_____

Patient Name: Last _____ First _____ Middle ___ Age ____
Date of Birth _____ Social Security # _____ Sex (M/F) _____
Home Address _____
City _____ State _____ Zip _____
Home Telephone _____ Work Telephone _____ Cell # _____
Correspondence by email: ☐ YES ☐ NO E-Mail Address _____
Drivers License # _____ Marital Status: ☐S ☐M ☐D ☐W

Employer _____
Occupation (if retired, former occupation) _____
Spouse Name _____ Spouse Social Security # _____
Mother/Father Name (if patient a minor) _____
To whom shall statements be sent, if other than patient? _____
Address if different from patient _____ Phone _____

Contact Person in Case of Emergency:
Name _____ Phone _____ Relationship _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Dental Insurance Information

Primary Dental Insurance _____

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID#: _____ Group # _____
Insured's Address: _____
Street City State Zip
Insured's Employer Name _____
Address: _____
Street City State Zip
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____
Insurance Plan Name and Address: _____

Secondary Dental Insurance _____

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID#: _____ Group # _____
Insured's Address: _____
Street City State Zip
Insured's Employer Name _____
Address: _____
Street City State Zip
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____
Insurance Plan Name and Address: _____

Authorization

I hereby authorize my insurance carrier to pay benefits directly to HEYS DENTAL, PLLC. I understand I am responsible to pay for services not covered by my insurance. I also authorize the release of any information regarding a claim to my insurance company for procedures performed by Heys Dental, PLLC. I also understand I am responsible to pay for expenses that may accrue due to collection and or interest charges.

SIGNATURE _____ **DATE** _____