HAWS FAMILY DENTISTRY

Patient's Name_____Driver's License #_____

Address _____City/State_____Zip _____

Home Phone_____Cell Phone_____Work Phone_____

Patient's SS #_____ Sex: M _____ F _____ Marital Status: M____ S____ W____ D____

Patients' Email Address _____ I would like to receive info by email: YES NO

Patient's Employer_____City/State _____

Parent/or Spouse's Name_____Parent/or Spouse's SS #_____

Parent/or Spouse's Date of Birth_____Work Phone_____ Cell Phone_____

Parent/or Spouse's Employer_____

Emergency Contact_____Relationship to Patient_____

Phone #_____Address_____

How did you hear about our office? Internet____Facebook____Patient Referral____Name_____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name of responsible party_____Date of Birth_____

Address _____City/State_____Zip Code_____

Home Phone_____ Cell Phone_____SS #_____

Email Address_____Driver's License #_____

Employer_____ Work Phone_____

Employer's Address_____City/State_____Zip_____

Will dental insurance be involved? YES NO Name of Insurance Co. _____

Will secondary insurance be involved? YES NO Name of Insurance Co. _____
If yes, please have your identification card available so we may make a copy.

METHOD OF PAYMENT

☐ Payment in full at each appointment (cash, check or credit card)

☐ Care Credit

My mobile number is_____. I authorize the use of my mobile phone number (previously listed) to receive scheduling and billing messages. I agree to update this office if my mobile number changes. (Please initial)_____

Signature _____ Date _____
Patient or Responsible Party