John L. Hyatt, D.D.S., M.S.

Practice Limited to Periodontics

Acquaintance Information

Patient Information:

Last Name _____ First Name _____ M.I. _____

Address (Residence) _____ City _____ State _____ ZIP Code _____

Mailing Address (If Different) _____ City _____ State _____ ZIP Code _____

Phone Number _____ Height _____ Weight _____ Social Security Number _____ Date of Birth _____

Employer _____ Address _____ City _____ State _____ ZIP Code _____

Employer Phone _____ Is it O.K. to call you at work? YES NO

S M D W
Marital Status

Name of Spouse _____

Name of Nearest Relative not living with you _____ Relation _____ Phone Number _____

Address _____ City _____ State _____ ZIP Code _____

Physician _____ Phone Number _____

Address _____ City _____ State _____ ZIP Code _____

If Child (Under 18):

Name of Parent/Guardian/Person Responsible for Account _____ Phone Number _____ Social Security Number _____

Address _____ City _____ State _____ ZIP Code _____

Employer _____ Phone Number _____

The undersigned patient (Parent/guardian if patient is under 18) understands and agrees that he/she is responsible for all fees for all professional services rendered to the patient. Necessary forms will be completed to expedite insurance company payments. Insurance payments are assigned to the patient, and the patient is responsible for all fees the day services are rendered unless prior arrangements have been made.

_____
Signature

Whom may we thank for referring you? _____

With what dental problems may we help you? _____