'OLFGANG J. BAY D.M.D.

Welcome to our practice! Take a few minutes to complete this form.
Please answer all questions. We look forward to having you as a patient!

PLEASE PRINT

Date _____

PATIENT INFORMATION

Name_____ Sex ☐ M ☐ F Birthdate: Month _____ Day_____Year _____

Address: City/State/Zip_____

Home Phone:_____Cell Phone_____ Work Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City/State _____

Status: ☐ FT ☐ PT Expected Grad Date _____

Employer _____ Work Phone _____

Spouse or Parent/Guardian Name_____ Home Phone _____ Work/Cell Phone_____

Who can we thank for referring you to our practice?_____

Emergency Contact/Relationship to You _____ Home Phone _____ Work/Cell Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____

Address: City/State/Zip _____

Home Phone:_____Cell Phone_____ Work Phone _____

Social Security Number _____ Birthdate: Month _____ Day_____Year _____

Relationship to Patient _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient_____

Birthdate: Month _____ / Day_____/Year _____ Social Security # _____ ID # _____

Address: City/State/Zip _____Phone Number _____

Insurance Company & Address _____

Group No. _____ Toll Free Phone #_____

SECONDARY INSURANCE IF APPLICABLE

Name of Insured _____ Relationship to Patient _____

Birthdate: Month _____ / Day_____/Year _____ Social Security # _____ ID # _____

Address: City/State/Zip _____Phone Number _____

Insurance Company & Address _____

Group No. _____ Toll Free Phone #_____