

PATIENT REGISTRATION

ID: _____ **Chart ID:** _____
First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Patient is: Policy Holder Responsible Party **Preferred Name:** _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Address 2: _____
City: _____ State: _____ Zip code: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
Birth Date: _____ Social Sec #: _____ Driver's License: _____
Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____
City: _____ State: _____ Zip code: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
Sex: Male Female Married Single Divorced Separated Widowed
Birth Date: _____ Age: _____ Social Sec #: _____ Driver's License: _____
E-mail: _____ I would like to receive correspondences via e-mail.

Section 2 **Section 3**

Employment Status: Full Time Part Time Retired Additional Comments: _____
Student Status: Full Time Part Time
Medicaid ID: _____ Pref. Dentist: _____
Employer ID: _____ Pref. Pharmacy: _____
Carrier ID: _____ Pref. Hygienist: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Employer: _____ Insurance Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____
Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Employer: _____ Insurance Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____
Rem. Benefits: _____ Rem. Deduct: _____