

PATIENT REGISTRATION

ID: _____Chart ID: _____

First Name: _____Last Name: _____Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible PartyPreferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____Last Name: _____Middle Initial: _____

Address: _____Address 2: _____

City, State, Zip: _____Pager: _____

Home Phone: _____Work Phone: _____Ext: _____Cellular: _____

Birth Date: _____Soc Sec: _____Drivers Lic: _____

☐ 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: _____Pager: _____

Home Phone: _____Work Phone: _____Ext: _____Cellular: _____

Sex: ☐ Male ☐ FemaleMarital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____Age: _____Soc Sec: _____Drivers Lic: _____

E-mail: _____☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____Pref. Dentist: _____

Employer ID: _____Pref. Pharmacy: _____

Carrier ID: _____Pref. Hyg: _____

Section 3

xxx _____

Primary Insurance Information

Name of Insured: _____Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____Insured Birth Date: _____

Employer: _____Ins. 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: _____Ins. Company: _____

Address: _____Address: _____

Address 2: _____Address 2: _____

City, State, Zip: _____City, State, Zip: _____

Rem. Benefits: _____Rem. Deduct: _____