

PATIENT REGISTRATION

ID: Chart ID:
First Name: Last Name: Middle Initial:
Preferred Name:

Patient is : ☐ Responsible Party ☐ Policy Holder

Responsible Party: (if someone other than the patient)

First Name: Last Name: Middle Initial:
Address: Address 2:
City, State, Zip:

Home Phone: Work Phone: Cell Phone:
Birth date: Social Security #: Drivers Lic#:

☐ Responsible Party is Policy Holder for Patient ☐ Primary Policy Holder ☐ Secondary Policy Holder

Patient Information:

Address: Address 2:
City, State, Zip:

Home Phone: Work Phone: Cell Phone:

Sex: ☐ Female ☐ Male Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth date: Social Security #: Drivers Lic#:

E-mail: ☐ I would like to receive email correspondences

Patient Information (section 2):

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Unemployed

Student Status: ☐ Full Time ☐ Part Time

Preferred Dentist: Preferred Hygienist: Preferred Pharmacy:

Referred By:

Medicaid ID:

Primary Insurance Information:

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

Employer ID: Carrier ID:

Insured Social Security #: Insured Birth date:

Employer: Insurance Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Secondary Insurance Information:

| | |
|----------------------------|--|
| Name of Insured: | Relationship to Insured: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other |
| Employer ID: | Carrier ID: |
| Insured Social Security #: | Insured Birth date: |
| Employer: | Insurance Company: |
| Address: | Address: |
| Address 2: | Address 2: |
| City, State, Zip: | City, State, Zip: |