Jennifer A. McConathy, D.D.S

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: ________ Pager: ____________

Home Phone: ____________ Work Phone: ____________ Ext: ______ Cellular: ____________

Birth Date: ____________ Social 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 ☐ Female: Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: ____________ Age: ____ Social Security: ____________ Drivers License: ____________

E-Mail Address: ____________ I would prefer to receive correspondences via e-mail ☐

Patient Information(section 2):

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Emergency Contact Name: ____________

Medicaid ID: ____________ Pref. Dentist: ____________ Emergency Contact Phone: ____________

Employer ID: ____________ Pref. Pharmacy: ____________

Carrier ID: ____________ Pref. Hygienist: ____________

Primary Insurance Information:

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

Insured Social Security: ____________ Insured Date of Birth: ____________

Employer: ____________

Address: ____________

Address 2: ____________

City: ____________ State: ______ Zip: ________

Rem. Benefits: ____________ Rem Deduct: ____________

Insurance Company: ____________

Address: ____________

Address 2: ____________

City: ____________ State: ______ Zip: ________

Secondary Insurance Information:

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

Insured Social Security: ____________ Insured Date of Birth: ____________

Employer: ____________

Address: ____________

Address 2: ____________

City: ____________ State: ______ Zip: ________

Rem. Benefits: ____________ Rem Deduct: ____________

Insurance Company: ____________

Address: ____________

Address 2: ____________

City: ____________ State: ______ Zip: ________

Email Form