



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:	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 Social Security:	Insured Date of Birth:
Employer:	Insurance Company:
Address:	Address:
Address 2:	Address 2:
City: State: Zip:	City: State: Zip:
Rem. Benefits: Rem Deduct:	