

# Ross & Fredrickson, D.D.S.

## PATIENT REGISTRATION

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder Preferred Name: \_\_\_\_\_  
 Responsible Party

### Responsible Party (if someone other than the patient)

First Name: _____	Last Name: _____	Middle Initial: _____
Address: _____	Address 2: _____	
City, State, Zip: _____	Cellular: _____	
Home Phone: _____	Work Phone: _____	Ext: _____
Birth Date: _____	Social Security #: _____	Drivers License: _____
<input type="radio"/> Responsible Party is also a Policy Holder for Patient <input type="radio"/> Primary Insurance Policy Holder <input type="radio"/> Secondary Insurance Policy Holder		

### Patient Information

Address: _____	Address 2: _____		
City, State, Zip: _____	Cellular: _____		
Home Phone: _____	Work Phone: _____	Ext: _____	
Sex: <input type="radio"/> Male <input type="radio"/> Female	Martial Status: <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Widowed		
Birth Date: _____	Age: _____	Social Security #: _____	Drivers License: _____
E-mail: _____	<input type="checkbox"/> I would like to receive correspondences via e-mail.		
-----Section 2-----		-----Section 3-----	
Employment Status: <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Retired	DO NOT R/S due to BA: _____		
Student Status: <input type="radio"/> Full Time <input type="radio"/> Part Time			
Medicaid ID: _____	Prof. Dentist: _____		
Employer ID: _____	Prof. Pharmacy: _____		
Carrier ID: _____	Prof. Hyg: _____		

### Primary Insurance Information

Name of Insured: _____	Relationship to Insured: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other
Insured Soc. Sec: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
Rem. Benefits: _____ .00	Rem. Deduct: _____ .00

### 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
Insured Soc. Sec: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
Rem. Benefits: _____ .00	Rem. Deduct: _____ .00