

# PATIENT REGISTRATION

**Seth C. Rumley, DDS, PA**

**James A. Whitehurst , DDS**

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

Preferred Name: \_\_\_\_\_

Patient is:  Responsible Party  Policy Holder  Minor

**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

**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

Referred By: \_\_\_\_\_

Medicaid ID (if applicable): \_\_\_\_\_

**Primary Insurance Information:**

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child    Other

Employer ID: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_

Insured Social Security #: \_\_\_\_\_ Insured Birth date: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_