

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: _____	Soc Sec: _____	Drivers Lic: _____
<input type="checkbox"/> Responsible Party is also a Policy Holder for Patient	<input type="checkbox"/> Primary Insurance Policy Holder	<input type="checkbox"/> Secondary Insurance Policy Holder

Patient Information _____

Address: _____	Address 2: _____	
City: _____	State / Zip: _____	Pager: _____
Home Phone: _____	Work Phone: _____	Ext: _____ Cellular: _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Birth Date: _____	Age: _____	Soc Sec: _____ Drivers Lic: _____
E-mail: _____	<input type="checkbox"/> I would like to receive correspondences via e-mail.	

<p>Section 2</p> Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time Medicaid ID: _____ Pref. Dentist: _____ Employer ID: _____ Pref. Pharmacy: _____ Carrier ID: _____ Pref. Hyg: _____	<p>Section 3</p> CC Exp / CVS _____ Previous Dentist _____ Emergency Contact _____ CC # _____ Emergency # _____
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Primary Insurance Information _____

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