

**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: \_\_\_\_\_

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: \_\_\_\_\_

Soc Sec: \_\_\_\_\_

Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status:  Full Time  Part Time  Retired

Student Status:  Full Time  Part Time

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyg: \_\_\_\_\_

General DDS \_\_\_\_\_

DDS Phone \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Orthodontist \_\_\_\_\_

Other \_\_\_\_\_

Primary Insurance Information

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