PATIENT REGISTRATION

ID:_____ Chart ID:_____

First Name:_____ Last Name:_____ Middle Initial:____

Preferred Name:_____

Patient is: □ Responsible Party □ Policy Holder

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 ○ Secondary 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

Preferred Dentist:_____ Preferred Hygienist:_____
Preferred Pharmacy:_____

Referred By:_____

Medicaid ID:_____

Primary Insurance Information:

Name of Insured:_____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID:_____ Carrier ID:_____

Insured Social Security #:_____ Insured Birth date:_____

Employer:_____ Insurance Company:_____

Address:_____ Address:_____

Address 2:_____ Address 2:_____

City, State, Zip:_____ City, State, Zip:_____

Secondary Insurance Information:

Name of Insured:_____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID:_____ Carrier ID:_____

Insured Social Security #:_____ Insured Birth date:_____

Employer:_____ Insurance Company:_____

Address:_____ Address:_____

Address 2:_____ Address 2:_____

City, State, Zip:_____ City, State, Zip:_____