

**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.

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

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

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

<p>Employer: _____</p> <p>Address: _____</p> <p>Address 2: _____</p> <p>City, State, Zip: _____</p> <p>Rem. Benefits: _____</p>	<p>Ins. Company: _____</p> <p>Address: _____</p> <p>Address 2: _____</p> <p>City, State, Zip: _____</p> <p>Rem. Deduct: _____</p>
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\_\_\_\_\_ Secondary Insurance Information \_\_\_\_\_

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

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

<p>Employer: _____</p> <p>Address: _____</p> <p>Address 2: _____</p> <p>City, State, Zip: _____</p> <p>Rem. Benefits: _____</p>	<p>Ins. Company: _____</p> <p>Address: _____</p> <p>Address 2: _____</p> <p>City, State, Zip: _____</p> <p>Rem. Deduct: _____</p>
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