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   emergency contact _____
                                                                   Medicaid ID _____
Student Status: ☐ Full Time   ☐ Part Time   emergency contact # _____

Medicaid ID: _____   Pref. Dentist: _____   Care Credit # _____
                                                                   Dentaquest _____
Employer ID: _____   Pref. Pharmacy: _____   Healthplex _____

Carrier ID: _____   Pref. Hyg: _____

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: _____