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: _____ Driver's 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: _____ Soc. Sec: _____ Driver's Lic: _____

E-mail: _____ ❑ I would like to receive correspondences via email

SECTION 2

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.: _____

SECTION 3 - Referral Source:

PRIMARY INSURANCE INFORMATION

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

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

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

Rem. Benefits: _____.00 Rem. Deduct: _____00

SECONDARY INSURANCE INFORMATION

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

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

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

Rem. Benefits: _____.00 Rem. Deduct: _____00