PATIENT REGISTRATION

TIME: DATE:

ID: CHART ID:
First Name: Last Name: Middle Initial:
Preferred Name:
Patient is: Policy Holder Responsible Party

Responsible Party (if someone other than the Patient)

First Name: Last Name: Middle Initial:
Address: Address 2:
City: State: Zip:
Home Phone: Work Phone: Ext: Cell phone:
Birth date: Soc. Security #: Driver License:
Responsible Party also is a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: Address 2:
City: State: Zip:
Home Phone: Work Phone: Ext: Cell phone:
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birth date: Age: Social Security: Drivers License:
Email: I would like to receive correspondences via e-mail.

Section 2

Employment Status: Full Time Part Time Retired
Student Status: Full Time Part Time
Medicaid ID: Preferred Dentist:
Employer ID: Preferred: Pharmacy:
Carrier ID: Preferred Hygiene:

Section 3

Referred by:
Previous Dentist:
Emergency Contact:
Emergency Contact #:

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: Address2:
City, State, Zip: City, State, Zip:
Rem. Benefits: Rem. Deductible:

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: Address2:
City, State, Zip: City, State, Zip:
Rem. Benefits: Rem. Deductible: