

**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

Employment Status:  Full Time

Part Time

Retired

Student Status:  Full Time

Part Time

Medicaid ID:

Prof. Dentist:

Employer ID:

Prof. Pharmacy:

Carrier ID:

Prof. Hyg:

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:

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: