

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Patient is : Responsible Party Policy Holder

Responsible Party: (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth date: _____ Social Security #: _____ Drivers Lic#: _____

Responsible Party is Policy Holder for Patient Primary Policy Holder Secondary Policy Holder

Patient Information:

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: Female Male Marital Status: Married Single Divorced Separated Widowed

Birth date: _____ Social Security #: _____ Drivers Lic#: _____

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

Patient Information (section 2):

Employment Status: Full Time Part Time Self Employed Retired Unemployed

Student Status: Full Time Part Time

Preferred Dentist: _____ Preferred Hygienist: _____ Preferred Pharmacy: _____

Referred By: _____

Medicaid ID: _____

Primary Insurance Information:

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

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

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

Secondary Insurance Information:

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

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

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