

**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

Student Status:  Full Time  Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Emergency Contact  
Emergency Contact #  
Social Security #  
Secondary Contact  
Seoncdary Contact #  
Care Credit  
Other CC#

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: