PATIENT REGISTRATION

ID:		Chart ID:		Date:	Click here to enter a date.
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:	Click here.	Soc Sec:		Drivers Lic:			

☐ Responsible Party is also a Policy Holder for a Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy

Patient Information

Address:			Address 2:				
City:		State:		Zip:		Pager:	
Home Phone:		Work Phone:		Ext:		Cellular:	
Sex:	◉ Male ○ Female	Marital Status:	◉ Married ○ Divorced ○ Separated ○ Widowed ○ Single			Age:	
Birth Date:	Click here.	Soc Sec:				Drivers Lic:	
E-mail:			☐ I would like to receive correspondence via email.				

Section 2				Section 3	
Employment Status:	○ Full Time ○ Part Time ◉ Retired			Referred By:	
Student Status:	◉ Full Time ○ Part Time			Previous Dentist:	
Medicaid ID:		Pref. Dentist:		Emergency Contact:	
Employer ID:		Pref. Pharmacy:		Emergency Contact #:	
Carrier ID:		Pref.Hyg:			

Primary Insurance Information

Name Of Insured:		Relationship to Insured:	○ Self ○ Spouse ◉ Child ○ Other
Insured Soc.Sec:		Insured Birth Date:	Click here.

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:		Click here.		
Employer:							Ins.Company:				
Address:							Address:				
Address 2:							Address 2:				
City:		State:		Zip:			City:		State:		Zip:	
Rem. Benefits:		Rem. Deduct:									