PATIENT REGISTRATION

Chart ID: _____ Date: _____/_____/_____

Responsible Party *(if someone other than the patient)*

First Name: _____ Last Name: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ - _____ Work Phone: (_____)_____ - _____ Cellular (_____)_____ - _____

Birth Date: _____/_____/_____ Soc Sec #: _____ - _____ - _____ Divers Lic #: _____

❑ Responsible Party is also a Policy Holder for Patient

❑ Primary Insurance Policy Holder ❑ Secondary Insurance Policy Holder

Patient Information

First Name: _____ Last Name: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ - _____ Work Phone: (_____)_____ - _____ Cellular (_____)_____ - _____

Birth Date: _____/_____/_____ Soc Sec #: _____ - _____ - _____ Divers Lic #: _____

Age: _____ Sex: ❑ Male ❑ Female Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Email: _____ ❑ I would like to receive correspondences via e-mail

Employment Status: ❑ Full Time ❑ Part Time ❑ Retired Pref. Dentist: _____

Student Status: ❑ Full Time ❑ Part Time Pref. Pharmacy: _____

MEDICAID ID: _____ Pref. Hygienist: _____

Primary Insurance Information

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

Insured Soc Sec: _____ - _____ - _____ Insured Birth Date: _____/_____/_____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

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

_____ _____

Remaining Benefits: _____ Remaining Deductible: _____

Secondary Insurance Information

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

Insured Soc Sec: _____ - _____ - _____ Insured Birth Date: _____/_____/_____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

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

_____ _____

Remaining Benefits: _____ Remaining Deductible: _____