



PATIENT REGISTRATION

First Name: \_\_\_\_\_ Chart ID: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder  Responsible Party Preferred Name: \_\_\_\_\_ ID: \_\_\_\_\_

Responsible Party (if someone other than the patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: City, States, Zip: \_\_\_\_\_ Address 2: \_\_\_\_\_

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

Email: \_\_\_\_\_

Patient

Information Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

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: \_\_\_\_\_

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: City, \_\_\_\_\_ Address 2: \_\_\_\_\_

State, Zip: Rem. \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Benefits: \_\_\_\_\_ Rem. Deduct: \_\_\_\_\_