PATIENT REGISTRATION

ID: _____ Chart ID: _____

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

Patient Is: ☐ Policy Holder   Preferred Name: _____
          ☐ Responsible Party

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

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.: _____

Section 3

Additional Comments.

Primary Insurance Information

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

Insured Soc. Soc: _____ 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: _____