



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: _____

Phone: (H) _____ (W) _____ Ext: _____ (C) _____

Birth Date: _____ SSN: _____ Driver's Lic: _____

Responsible Party if also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Phone: (H) _____ (W) _____ Ext: _____ (C) _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ SSN: _____ Driver's Lic: _____

E-mail: _____ I would like to receive correspondence 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 SSN: _____ Insured Birth Date: _____

Employer: _____

Address: _____

City, State, Zip: _____

Insurance Company: _____

Address: _____

City, State, Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Insured SSN: _____ Insured Birth Date: _____

Employer: _____

Address: _____

City, State, Zip: _____

Insurance Company: _____

Address: _____

City, State, Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00