Patient Registration

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____
Patient is: ☐ Policy Holder ☐ Responsible Party

Responsible Party (if someone other than the patient)
First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Address 2: _____
City, State, Zip: _____
Home Phone: _____ Work Phone: _____ Ext. _____ Cell Phone: _____
Birth Date: _____ _____ __ SS#: _____ __ Drivers License: _____
☐ 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: _____
Home Phone: _____ Work Phone: _____ Ext. _____ Cell Phone: _____
Sex: ☐ Male ☐ Female
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Birth Date: _____ Age:___ SS#: _____ Drivers License: _____
Email:_____
Y ☐ N ☐ I would like to receive correspondences via email.

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Additional Comments:
Student Status: ☐ Full Time ☐ Part Time
Medicaid ID: _____ Preferred Dentist: _____
Employer ID: _____ Preferred Pharmacy: _____
Carrier ID: _____ Preferred Hygienist: _____

Primary Insurance Information
Name of Insured: _____
Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured SS#: _____ 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 SS#: _____ Insured Birth Date: _____

Employer:_____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

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

Rem. Benefits: _____ Rem. Deduct: _____